HEALTH SERVICES AND DEVELOPMENT AGENCY MEETING
MAY 28, 2014
APPLICATION SUMMARY

NAME OF PROJECT:	Summit Medical Center
PROJECT NUMBER:	CN1402-004
ADDRESS:	5655 Frist Boulevard Hermitage (Davidson County), TN 37076
LEGAL OWNER:	HCA Health Services of Tennessee, Inc. 5655 Frist Boulevard Hermitage (Davidson County), TN 37076
OPERATING ENTITY:	NA
CONTACT PERSON:	John Wellborn (615) 665-2022
DATE FILED:	February 14, 2014
PROJECT COST:	$1,812,402.00
FINANCING:	Cash Reserves of the parent corporation, HCA

REASON FOR FILING:

The addition of eight (8) medical/surgical beds increasing the hospital's licensed bed complement from one hundred eighty-eight (188) to one hundred ninety-six (196) total licensed beds.

DESCRIPTION:

Summit Medical Center (SMC) is seeking approval for the addition of 8 medical/surgical beds to be located in a wing of the 7th floor that currently houses the hospital's outpatient sleep lab. The work to be performed to convert the wing to all-private patient rooms will include renovation of approximately 4,406 square feet of space and will include adding handicapped-accessible bathrooms. As a result of the proposed conversion, the hospital's total licensed bed complement will increase by 8 beds from 188 to 196 licensed acute care beds.

The addition of 8 medical surgical beds in this project is projected to relieve mid-week occupancy pressures and will complement SMC's most recent approved and completed certificate of need project, CN1304–011A. In that project, SMC converted the hospital's former 20 bed psychiatric unit to 8 medical surgical beds and a 12-bed inpatient rehabilitation unit with no net change to SMC's 188 total licensed bed complement.

SERVICE SPECIFIC CRITERIA AND STANDARD REVIEW

ACUTE CARE BED NEED SERVICES

1. The following methodology should be used and the need for hospital beds should be projected four years into the future from the current year:

   Using the latest utilization and patient origin data from the Joint Annual Report of Hospitals and the most current population projection series from the Department of Health, perform the following:

   Step 1

   Determine the current Average Daily Census (ADC) in each county.

   $$ADC = \frac{\text{Patient Days}}{\text{365 (366 in leap year)}}$$

   Step 2

   To determine the service area population (SAP) in both the current and projected year:

   a. Begin with a list of all the hospital discharges in the state, separated by county, and showing the discharges both by the county where the patient actually lives (resident discharges), and the county in which the patient received medical treatment.

   b. For the county in which the hospital is (or would be) located (service county), determine which other counties have patients who are treated in your county (resident counties). Treat all of the discharges from another state as if that whole state were a single resident county. The total discharges of residents from another

state should be calculated from state population estimates and the latest National Center for Health Statistics southeastern discharge rates.

c. For each resident county, determine what percent of their total resident discharges are discharged from a hospital in your service county (if less than one percent, disregard).

d. For each resident county, apply the percentage determined above to the county's population (both projected and current). Add together the resulting numbers for all the resident counties and add that sum to the projected and current population of your service county. This will give you the service area population (SAP).

Step 3

Determine projected Average Daily Census as:

$$\text{Projected ADC} = \text{Current ADC} \times \frac{\text{Projected SAP}}{\text{Current SAP}}$$

Step 4

Calculate Projected Bed Need for each county as:

Projected Need = Projected ADC + 2.33 x □Projected ADC

However, if projected occupancy:

$$\text{Projected Occupancy:} \quad \frac{\text{Projected ADC}}{\text{Projected Need}} \times 100$$

is greater than 80 percent, then calculate projected need:

$$\text{Projected Need} = \frac{\text{Projected ADC}}{.8}$$

Tennessee Department of Health's (TDH) Acute-Care Bed Need Projections Report for 2014 and 2018 indicates that there is a licensed bed surplus of 1,053 acute care beds and a staffed bed surplus of 428 beds in the 2-county service area based on the # of licensed beds reported to TDH in the CY2012 Joint Annual Report. In Davidson County, there is a licensed bed surplus of 940 beds and a staffed bed surplus of 315 beds.

***Important note**: review of the "Licensed Facilities Report" published by the Division of Health Facilities, Tennessee Department of Health, revealed that there were 4,029 licensed hospital beds of all types in Davidson County (excluding the 300 licensed psychiatric hospital beds in operation at Middle Tennessee Mental Health Institute), and 245 licensed beds in Wilson County for a total of 4,274 licensed beds in SMC's service area as of April 30, 2014. The licensed bed inventory decreases to 4,033 licensed acute care beds when excluding the 130 Long Term Acute Care (LTAC) beds (Kindred Hospital, Select Specialty Hospital) and 111 rehabilitation hospital beds (Vanderbilt Stallworth, Nashville Rehab). As a result, it appears that the acute care bed surplus is approximately 1,087 licensed beds in the 2-county service area when using today's licensed bed count maintained by TDH. The surplus could increase by another 26 beds from approximately 1,087 to 1,113 total licensed beds when Vanderbilt University Medical Center's remaining 26 of 246 approved but unimplemented CON beds are placed into service (CN0606-037A was approved for 141 additional beds and CN0710-075A for 105 additional beds). Please note the following table:*

County	Davidson (based on CY2012 JAR)	Wilson (based on CY2012 JAR)	Service Area Estimate (based on CY2012 JAR)	Service Area Estimate (based on April 2014 TDH Licensed Facilities Report)
2018 Acute Care Bed Need	2,814	132	2,946	2,946 Licensed
Licensed and Staffed Beds	3,754 Licensed 3,129 Staffed	245 Licensed 245 Staffed	3,999 Licensed 3,374 Staffed	4,274 Licensed*
Net Need/ -Surplus Licensed and Staffed Beds	-940 Licensed -315 Staffed	-113 Licensed -113 Staffed	-1053 Licensed -428 Staffed	-1,087 Licensed**

*Notes: * Licensed beds decrease to 4,033 beds when excluding licensed beds of LTAC and Rehab Hospitals. **Surplus could increase by approximately 26 licensed beds to 1,113 total beds when Vanderbilt's remaining 26 of 246 CON approved and unimplemented beds in CN0606-037A and CN0710-075A become operational. Sources: TDH Hospital Bed Need Projection, 2014-2018, HSDA records*

Based on licensed beds reported to TDH in the CY2012 JAR, the chart above indicates there is a net surplus of 1,053 licensed acute care beds and 428 staffed acute care beds in the service area of Davidson and Wilson Counties. However, it appears there may be a

larger net surplus of approximately 1,198 licensed beds when considering the current number of licensed hospital beds reported by the Division of Health Facilities, Tennessee Department of Health. Exhibit 1, page 18 contains additional information.
It appears that this criterion has not been met.

2. New hospital beds can be approved in excess of the "need standard for a county" if the following criteria are met:

    a) All existing hospitals in the projected service area have an occupancy level greater than or equal to 80 percent for the most recent Joint Annual Report. Occupancy should be based on the number of licensed beds that are staffed for two consecutive years.

Based on the Licensed Bed and Staffed Bed amounts in the table above and an average daily census of 2,187 patients per day, licensed and staffed bed occupancy for general acute care hospitals in the service area was 55% and 65%, respectively, in 2012 (source: 2012 Joint Annual Report, TDH and applicant's tables on pages 21-22 of the application).
It appears that this criterion has not been met.

    b) All outstanding CON projects for new acute care beds in the proposed service area are licensed.

There are outstanding CON projects for new acute care beds that are not fully implemented as indicated in the list of outstanding CON projects that follows the staff summary. Vanderbilt University Medical Center reports a total of 246 unimplemented "CON beds" in its CY2013 (Provisional) Joint Annual Report, which would include 141 beds approved in CN0606-037A on 9/27/2006 and 105 beds approved in CN0710-075A on 1/23/2008. However, review of the Division of Health Facilities, TDH, Licensed Facilities Report and HSDA records, including CON final progress reports and outstanding CON updates, reflects that approximately 220 of Vanderbilt's 246 "unimplemented CON beds" reported in its CY2013 Joint Annual report appear to be licensed and in service as of April 30, 2014. The remaining "Outstanding CON" projects listed at the back of the summary involve relocated or converted beds in the service area with no net bed changes.
It appears that this criterion is partially met.

    c) The Health Facilities Commission may give special consideration to acute care bed proposals for specialty health service units in tertiary care regional referral hospitals.

It appears that this criterion is not applicable

SUMMARY:

SMC proposes to increase its licensed bed complement from 188 to 196 total beds through the addition of 8 medical surgical beds to be located in approximately 4,406 square feet (SF) of existing space on the 7th floor that is currently used as SMC's 4-room outpatient sleep lab. The sleep lab will be converted to an 8-bed medical surgical patient unit with all private rooms and handicapped-accessible bathrooms. Additionally, the sleep lab will be relocated to approximately 3,000 SF of renovated space on the 4th floor of the existing medical office building attached to SMC's main campus and will retain its current 4 sleep room capacity. The cost and size of the space to be renovated in the project is shown in the following table excerpted from page 11R:

Component	Renovation Cost	SF of Renovation	Cost per SF
7th floor med-surg beds (8 beds)	$984,973	4,406 SF	$223.55 per SF
Sleep Lab relocated to MOB (4 rooms)	$176,160	3,000 SF	$58.72 per SF
Total project	$1,161,133	7,406 SF	$156.78 per SF

The hospital recently received approval in CN1304-011A, to convert 20 inpatient adult psychiatric beds to 8 medical/surgical beds and 12 inpatient rehabilitation beds through the termination of its adult inpatient psychiatric program. As of 4/24/14, the project has been completed and a final project report is in progress. The current bed mix at SMC compared to the proposed bed mix associated with this project is displayed in the following table from page 3R:

Summit Medical Center's Bed Mix

Bed Type	Current Beds	Proposed Beds	# Change
Med./Surg.	118	126	+8
Obstetrical	24	24	0
ICU/CCU	24	24	0
NICU	10	10	0
Adult Psych.	0	0	0
Rehab.	12	12	0
TOTAL	188	196	0

The applicant provides several reasons for the need of the project:

- Existing medical/surgical patients (amputation, stroke, burns, major trauma, joint replacements, etc.) will have improved access to beds on the service that are expected to reach 85% occupancy or greater in CY2015. Improved access will reduce waiting in the hospital Emergency Department, or being held in PACU/Recovery and ICU beds on other floors of the hospital.
- Recent conversion of 8 psychiatric beds to medical surgical/orthopedic beds approved in CN1304-011A will not fully relieve occupancy pressures on the medical-surgical bed service. In addition, as further documented in CN1304-011A, SMC has undergone recent expansion of the emergency department and designation as a Joint Commission-designated Primary Stroke Center in calendar year (CY) 2011. As a result of these other service improvements, the applicant maintains that hospital's medical-surgical bed resources are stretched tightly.
- Patients/families preference for general hospital, medical-surgical services closer to home. The applicant believes that the patient/family preference has and will continue to result in increased admissions of the service.
- Meet high occupancy trends of 85% or greater by adding the 8 proposed beds and increasing the capacity of the service from 118 to 126 beds (*the 118 beds became operational in March 2014*). This is noted on trend line graph found on page 15 of the application where occupancy of the unit averaged approximately 80% to 85% on 45 days in 2012 increasing to 96 days in 2013. Occupancy of the existing 118-bed service is projected to average 85% in CY2015.
- Increase more manageable and efficient utilization of the proposed 126 bed service's mid-week peak census levels by reducing the times that patients remain in the ED, the PACU or the ICU.
- Limited or very minimal adverse impact on other providers in Davidson or Wilson Counties based on the small number of additional licensed beds needed to meet SMC's peak occupancy census levels. The applicant maintains that the net impact of the additional 8 beds is estimated at less than 1% of the CY2018 projected acute care bed surplus in the 2-county service area.
- Sole hospital on eastern edge of Davidson County accessible to high growth Hermitage & Mt. Juliet communities with significant distance and drive times to alternative acute care facilities
- No reasonable means to de-licensing inpatient beds of the hospital or its other companion, HCA-owned hospitals in Davidson County to alleviate

any increase to the existing acute care bed surplus in the 2-county service area (Item 9, February 21, 2014 supplemental response). The applicant maintains that this option would not allow for management of inpatient services during peak hospital occupancy times throughout the year.

Summit Medical Center is 100 percent owned by HCA Health Services of Tennessee, whose parent organization is (through several corporate entities) HCA, Inc of Nashville, Tennessee. HCA is composed of locally owned facilities that include approximately 190 hospitals and 82 outpatient surgery centers in 23 states, England and Switzerland. Summit Medical Center is part of the locally managed HCA TriStar Group which operates hospitals in South Central Kentucky, Northern Georgia, and fourteen (14) hospitals in Tennessee. An organizational chart is enclosed in Attachment A.4.

According to the CY2012 Joint Annual Report, Summit Hospital is licensed for 188 beds and staffed 137 of its beds during the reporting period. The licensed and staffed hospital bed occupancy at Summit Medical Center was 62.2% and 85.4%, respectively in CY2012. The applicant reported licensed bed occupancy of 69.1% in CY2013 and projected 72.1% for CY2014. The following provides the Department of Health's definition of the two bed categories pertaining to occupancy information provided in the Joint Annual Reports:

Licensed Beds- The maximum number of beds authorized by the appropriate state licensing (certifying) agency or regulated by a federal agency. This figure is broken down into adult and pediatric beds and licensed bassinets (neonatal intensive or intermediate care bassinets).

Staffed Beds-The total number of adult and pediatric beds set up, staffed and in use at the end of the reporting period. This number should be less than or equal to the number of licensed beds.

The applicant identified 10 existing hospital facilities in Davidson and Wilson Counties excluding 6 facilities or campuses used for inpatient psychiatric, rehabilitation, and/or long term acute care services. Review of the CY2012 JAR and the Tennessee Department of Health "Licensed Facilities" report for the 2-county service area revealed that the 10 hospitals accounted for approximately 4,033 beds or 94% of the 4,274 total hospital licensed beds of all types in the 2-county service area.

The applicant provides a chart on page 18R of the 2/27/14 supplemental response of the driving distances and times from Summit Medical Center to the other general hospital facilities in the 2-county service area. None of the hospitals are further than approximately 21.5 miles, nor more than 24 minutes driving

time. A summary of the utilization of the 10 hospitals as reported to the Tennessee Department of Health (2012 Joint Annual Report) is displayed in the table below:

Utilization of Acute Care Beds in Davidson and Wilson Counties, 2012

Hospital	Distance From SMC	2014 Total Licensed Beds	# MED-SURG Beds Staffed (2012 JAR)	Admissions	ADC	Licensed Bed Occupancy
Centennial	13.6	657*	240	25,830	407	61.9%
Metro NV General	13.8	150	67	4,069	48	31.8%
St Thomas Midtown	13.1	683	222	24,189	307	45%
St. Thomas West	16.8	541	266	100,202	275	50.7%
Skyline - Nashville and Madison	16.8	395	134	52,021	143	66.9%
Southern Hills	11.1	126	53	17,845	49	40.7%
Summit	NA	188	110	10,779	117	62.3%
Center for Spinal Surgery	13.3	23	23	1,144	4	18.1%
Vanderbilt	13.4	1,025*	347	50,240	753	82.3%
UMC and McFarland	21.5	245	127	5,528	67	39.1%
Total	**14.8**	**4,033**	**1,589**	**158,250**	**2,167**	**60%**

**Note: Review of the CY2012 JAR (final) and the April 2014 Licensed Facilities Report published by the Division of Health Facilities, TDH revealed that the licensed beds of these hospitals differed from the amounts reported in the application (e.g. table provided on page 30 of the application). The licensed bed amounts in the table have been corrected to reflect the # of acute care beds licensed by TDH as of April 30, 2014. The amounts exclude 80 beds at Vanderbilt Stallworth Rehab, 31 beds at Nashville Rehab, 70 beds at Select Specialty Hospital, 60 beds at Kindred Hospital and 300 beds at Mid-TN Mental Health Institute. Also excluded are approximately 26 "Unimplemented CON beds" at Vanderbilt Medical Center (26 of 246 total additional beds approved in CN0606-037A and CN0710-075A).*

The applicant has noted a slight increase in the overall licensed bed occupancies of the general hospital facilities in the 2 county service area. A review of the chart displayed below indicates that 4 of the 10 hospitals with medical-surgical bed

capacity experienced increases in their total licensed bed occupancy from 2010 to 2012.

Service Area Licensed Bed Occupancy Trends, 2010-2012

Hospital	Licensed Beds as of 4/2014*	2010	2011	2012
Centennial	657	65.9%	62.9%	61.9%
Metro NV General	150	42%	38.4%	31.8%
St Thomas-Midtown	683	46.3%	45.4%	45%
St Thomas-West	541	52.1%	51.9%	50.7%
Skyline Medical Center (includes Madison campus)	395	62.3%	66.5%	66.9%
Southern Hills	126	34.3%	35.8%	40.7%
Summit	188	56.5%	58.1%	62.3%
Ctr. for Spinal Surgery	23	20.3%	17.9%	18.1%
Vanderbilt	1,025	79.3%	82.4%	82.3%
UMC - includes McFarland Rehab	245	44.3%	41.4%	39.1%
Total	**4,033**	**59.5%**	**59.6%**	**60%**

**Note: Licensed Beds in table are based on April 2014 Licensed Facilities Report for Davidson and Wilson Counties published by Division of Health Facilities, TDH. Please see footnotes to table on preceding page for identification of other facilities that were excluded from the licensed bed inventory.*

As further support of the need for the 8 additional medical -surgical beds due to peak occupancy concerns, HSDA staff asked the applicant to provide the medical & surgical bed utilization in calendar year 2013 of SMC and its Nashville based HCA companion hospitals in the service area. While not specifically broken out in the TDH Joint Annual Report, the information was provided from internal HCA hospital management records in the 2/21/14 supplemental response as follows:

Medical-Surgical Utilization of HCA Nashville Area Hospitals, 2013

Hospital	Med-Surg Beds	Admissions	Patient days	Occupancy
Centennial	240	17,094	68,042	77.7%
Skyline	134	8,361	34,583	70.7%
So Hills	53	3,267	12,227	63.2%
Summit	110	7,589	31,294	77.9%
HCA Totals	**537**	**36,311**	**146,146**	**74.6%**

Source: applicant, 2/21/14 supplemental response. Medical-Surgical beds accounted for approximately 48% of the four HCA-Nashville hospital's total licensed beds in 2013.

SMC's primary service area is Davidson and Wilson Counties, which accounted for 9,045 or 87% of the hospital's 10,737 total admissions in CY 2012, an increase of 7.6% from 8,404 admissions in CY2011. By county, Davidson and Wilson County residents accounted for approximately 6,039 (58%) and 3,006 (29%) of total hospital admissions in CY2012. Admissions to the med-surg service also mirror this trend, as residents of the 2 counties accounted for approximately 88% of SMC's 7,589 medical-surgical admissions in CY2013.

Population projections based on the 2013 US Census from the Tennessee Department of Health's Division of Health Statistics indicates that the general population of the applicant's primary service area in 2014 is estimated to be 780,458 and is expected to grow 4.5% to 815,687 by 2018. This growth rate compares to the State's growth rate of 3.7% for the same time period. The age 65+ population in the service area is expected to increase by 16.3% from 92,319 to 107,339 individuals during this time period compared to a statewide growth rate of 12.3%. In 2017, individuals age 65+ are expected to account for approximately 13.2% of the two county service area population compared to 16.1% for Tennessee. The number of TennCare enrollees residing in the service area equates to 17.2% of the population, with Davidson County having the largest population proportion of TennCare enrollees (18.2%) and Wilson County having the lowest proportion (11.7%).

As noted, in applying the *Guidelines for Growth's* acute care bed need formula, the need for acute care beds in the 2-county service area is 2,946 beds, while the current supply of licensed beds is 4,144 hospital beds of all types (*excluding 130 total LTAC beds, 300 MTMHI psychiatric hospital beds and Vanderbilt's remaining 26 unimplemented CON beds*) leaving a surplus of approximately 1,198 beds.

The applicant expects the proposed 126 medical - surgical bed service to reach 7,934 admissions and 32,716 patient days (80% occupancy) in the first year of the project (2015) increasing to 8,172 admissions and 33,698 patient days (82.5% occupancy) in 2016. The details of the applicant's methodology with overview of total hospital utilization by major bed service can be found on page 32 of the original application. A summary of the applicant's historical and projected utilization for the medical surgical service compared to totals of SMC is presented in the following chart:

SMC's Historical and Projected Bed Occupancy

Service	2012	2013	2014	2015 (Year 1)	2016 (Year 2)
Med- Surg	83% 110 beds	87.5% 110 beds	83% * 118 beds	80% 126 beds	83% 126 beds
Total	62.3% 188 beds	69% 188 beds	72% 188 beds	71% 196 beds	73% 196 beds

** Note: # med/surg beds increased as result of conversion of former adult psych beds, CN1304-011A*
Sources: page 32 of application, CY2012 JAR and HSDA records

The applicant estimates that the addition of the 8 medical-surgical beds will not affect any hospital charges and will mirror most frequent charges by admission diagnosis shown in the table on page 46a of the application. The projected average gross charge is $12,824 per day in year one increasing to $13,249 in the second year. With the average deduction from operating revenue of approximately 81% of gross charges, SMC anticipates an average Net Operating Revenue of $2,477 per day in 2015 increasing by approximately 2.5% to $2,540 in year two. Net Operating Income after expenses is projected to be $115,886 in the first year and $248,694 in the second year.

The applicant states that the additional 8 med-surg beds will require 7 full time equivalent (FTE) direct nursing staff (RNs and certified nurse technicians) in year one adding 1.50 FTEs in year two. With all 126 med-surg beds in service beginning 2015, total staffing for the department is expected to average approximately 162.5 FTEs per year for the initial two years of the project.

The applicant anticipates that the 8 additional medical surgical beds will generate approximately $6,104,000 of gross operating revenues in the first year of the project, including $2,789,528 in Medicare (45.7%) and $665,336 in TennCare (10.9%). The applicant indicates they have contracts with all three TennCare MCOs available to its service area population: United HealthCare Community Plan (formerly AmeriChoice), TennCare Select and AmeriGroup. Comparison of SMC's Medicare and Tenncare payor mix to other general hospitals in the service area is displayed in the following table:

Medicare & TennCare Payor Mix of SMC and Other Hospitals in PSA, 2012

Hospital	Total Hospital Gross Revenue	Medicare Gross Revenue (as a % of Total)	Tenncare/Medicaid Gross Revenue (as a % of Total)
Centennial	$2,181,217,313	$1,287,172,303 (59%)	$244,226,787 (11%)
Metro NV General	$226,172,521	$49,214,259 (22%)	$54,848,131 (24%)
St Thomas Midtown	$1,260,376,438	$651,405,900 (52%)	$157,845,690 (12%)
St Thomas West	$1,405,480,380	$962,629,552 (69%)	$87,324,111 (6%)
Skyline-Nashville	$928,727,278	$655,172,776 (71%)	$112,215,643 (12%)
Skyline-Madison	$104,048,767	$43,477,919 (42%)	$27,105,436 (26%)
Southern Hills	$404,916,361	$216,235,553 (53%)	$66,031,686 (16%)
Summit	**$755,732,354**	**$449,247,319 (59%)**	**$80,464,928 (11%)**
Center for Spinal Surgery	$120,064,474	$25,145,813 (21%)	$3,763,128 (3%)
Vanderbilt	$5,453,993,390	$1,754,042,759 (32%)	$993,426,703 (18%)
Service Area Total	**$13,456,448,446**	**$6,093,744,153 (45%)**	**$1,827,252,243 (14%)**

Review of SMC's Historical Data Chart indicates the hospital has experienced several profitable years during the 3 years reported (2011-2013). Net Operating

Income Less Capital Expenditures was $12,414,115 for 2011, $18,407,255 in 2012 and $19,670,547 in 2013.

The source of funding for the project is identified as a cash transfer from the applicant's parent (HCA, Inc.) to the applicant's division office (TriStar Health System). A 02/10/14 letter from HCA TriStar's Controller attests to HCA's ability to finance the project. Review of the HCA's Holdings financial statement as of 02/14/14 revealed current assets of $8,037 billion and current liabilities of $5,695 billion for a current ratio of 1.46 to 1.0. Current ratio is a measure of liquidity and is the ratio of current assets to current liabilities which measures the ability of an entity to cover its current liabilities with its existing current assets. A ratio of 1:1 would be required to have the minimum amount of assets needed to cover current liabilities.

The total estimated project cost is $1,812,402.00. The majority of the cost is the renovation cost of $1,161,133 (64%). Related costs include $88,000 for architectural and engineering fees, $464,185 for moveable equipment, $385,000 and $65,015 for the contingency fund.

The applicant has submitted the required corporate documentation and real estate title. Staff will have a copy of these documents available for member reference at the meeting. Copies are also available for review at the Health Services and Development Agency office.

Should the Agency vote to approve this project, the CON would expire in three years.

CERTIFICATE OF NEED INFORMATION FOR THE APPLICANT:

There are no other Letters of Intent, pending applications or outstanding Certificates of Need for this applicant.

Denied Applications:

Summit Medical Center, CN1206-029D, was denied at the September 26, 2012 Agency meeting. The application was for the for the establishment of a 20 bed acute inpatient rehab unit and service in its hospital facility by converting 20 adult psychiatric beds and reclassifying the adult psychiatric unit to an inpatient rehab unit. The estimated cost was projected to be **$2,500,000.00** *Reason for Denial: the application did not meet the statutory criteria.*

HCA has financial interests in this project and the following:

Outstanding Certificates of Need

Hendersonville Medical Center, CN1302-002A, has an outstanding Certificate of Need which will expire on August 1, 2016. It was approved at the June 26, 2013 Agency meeting to construct a new fourth floor of medical surgical beds and initiate Level IIB Neonatal Intensive Care services in a new six (6) licensed Level IIB Neonatal Intensive Care Unit (NICU) on its campus at 355 New Shackle Island Road, Hendersonville (Sumner County) Tennessee, 37075. The proposed project will not change the total licensed bed complement. The hospital currently holds a single consolidated license for 148 general hospital beds, of which 110 are located at its main Hendersonville campus and 38 are located at its satellite campus at 105 Redbud Drive, Portland (Sumner County), TN 37148. The applicant will relocate 13 beds from the satellite campus to the main campus, resulting in 123 licensed beds at the Hendersonville campus and 25 licensed beds at the Portland satellite campus. The estimated cost of the project is **$32,255,000.00.** *Project Status: per 5/12/14 e-mail, the Chief Operations Officer of the medical center advised that the hospital is in process of finishing design drawings over the next 90 -120 days. Once approved, construction is expected to begin in early 2015.*

Natchez Surgery Center, CN1002-011A, has an outstanding Certificate of Need which will expire on July 1, 2015. It was approved at the May 26, 2010 Agency meeting for the establishment of an ambulatory surgical treatment center (ASTC) with three (3) operating rooms and three (3) procedure rooms. After approval, CN801-001A was surrendered which was a similar facility for this site at 107 Natchez Park Drive, Dickson (Dickson County), TN. The estimated cost of the project was **$13,073,892.00.** *Project Status: the applicant requested a modification at the March 2012 Agency meeting to extend the expiration date for three (3) years from July 1, 2012 to July 1, 2015,; reduce the number of operating rooms from three (3) to two (2) and procedure rooms from three (3) to one (1); reduce project costs by $4,201,823 from $13,073,892 to $8,872,069; and reduce square footage by 4,965 from 15,424 to 10,459 square feet. The Agency voted to defer consideration of this request until the May 2012 meeting so that it could be heard simultaneously with CN1202-008, Horizon Medical Center Emergency Department. Both CN1202-008 and the modification to CN1002-011A were approved at the May 2012 meeting. The most recent annual progress report was submitted on 6/27/13 and stated that the Natchez Surgery Center would be developed as a second stage of the freestanding emergency department (FSED) project. Groundbreaking of the ASTC was anticipated by December 2013 and completion by July 1, 2015. According to a 4/25/14 e-mail from a representative of HCA Healthcare, groundbreaking did not occur in December 2013 but the project is well underway. Architectural plans will be submitted to the state for approval the week of 5/5/2014 and*

plans will be released for bidding. The new groundbreaking date subject to state approval is June/July 2014. The ASTC project will require a seven month construction period with an anticipated opening date of January/February 2015.

Skyline Medical Center (Madison Campus), CN1110-040A, has an outstanding Certificate of Need which will expire on March 1, 2015. It was approved at the January 25, 2012 Agency meeting for expansion of an existing inpatient adolescent psychiatric unit by eleven (11) beds through the conversion of eleven (11) existing Medical/Surgical beds at its Madison Campus. The result will be a twenty-one (21) adolescent psychiatric bed unit while the hospital's total licensed bed complement of four hundred forty-six (446) acute care beds will remain unchanged. The estimated cost of the project is **$2,412,504.00.** *Project Status Update: a final project report was received on 4/25/14 from the Chief Operating Officer. Expansion of the adolescent psychiatric bed unit from 10 to 21 beds was completed & opened for public use on 2/18/14 at an amount of approximately $442,380 under the original estimated cost of the project.*

Parkridge Valley Hospital, CN1202-006AM has an outstanding Certificate of Need that will expire on July 1, 2015. The CON was approved at the May 23, 2012 Agency meeting for (1) the addition of sixteen (16) additional child and adolescent psychiatric beds to the sixty-eight (68) beds currently located on the satellite campus at 2200 Morris Hill Road, Chattanooga (Hamilton County) and (2) the relocation of all forty-eight (48) of its licensed adult psychiatric beds to a new campus. The current licensed hospital bed complement at Parkridge Valley Hospital, which is a satellite location of Parkridge Medical Center, will decrease from one hundred sixteen (116) beds to eighty-four (84) beds. The net result of this application is that only child and adolescent psychiatric beds will operate at this location. The estimated project cost of **$143,000.** *Project Status Update: the project cost was modified at the January 22, 2014 Agency meeting to a revised amount of* ***$706,006.*** *An e-mail was received on 4/25/14 from a representative of Parkridge indicating that Phase 1 of the Parkridge Valley Child & Adolescent campus construction (re-configuring space and moving walls), has been completed with the result that the number of patients who are housed three to a room has been reduced. Phase 2 involves the conversion of adult space to space appropriate for children and adolescents, including the conversion to all semi-private rooms in accordance with the industry norm of no more than two adolescents per room. Currently, architectural drawings are in the process of being finalized for review and approval by the Division of Health Care Facilities, Tennessee Department of Health. Parkridge expects to begin Phase 2 in early summer of 2014 with construction expected for a period of approximately 12 weeks. The representative stated that Parkridge is on track to complete the project within the $706,006 project cost estimate by the expiration date of July 1, 2015.*

Horizon Medical Center Emergency Department, CN1202-008A, has an outstanding Certificate of Need that will expire on July 1, 2015. The CON was approved at the May 23, 2012 Agency meeting to establish a satellite emergency department facility located at its Natchez Medical Park campus located at 109 Natchez Park Drive, Dickson (Dickson County). Estimated project cost is **$7,475,395.** *Project Status Update: according to a 4/25/14 e-mail from a representative of HCA Healthcare, the project is well underway. Architectural plans will be submitted to the state for approval the week of 5/5/2014 and plans will be released for bidding. The new groundbreaking date subject to state approval is June/July 2014. The ASTC project will require a seven month construction period with an anticipated opening date of January/February 2015.*

CERTIFICATE OF NEED INFORMATION FOR OTHER SERVICE AREA FACILITIES:

There are no other Letters of Intent, denied or pending applications for other entities proposing this type of service.

Vanderbilt Medical Center, CN0606-037A, has an outstanding certificate of need that will expire on July 1, 2015. The CON was approved at the September 27, 2006 Agency meeting for the continuance of facility's master plan: addition of 3rd bed tower with redistribution of 141 SNF beds to 141 new acute care beds; renovation and expansion of cardiac cath labs and hybrid ORs; addition of 14 newly constructed OR suites; and decommissioning 2 ORs. **The estimated project cost is $234,421,471.00.** *Project Status Update: according to a December 9, 2013 email from a Vanderbilt representative, the project continues with completion of the fifth floor catheterization lab anticipated for a mid-January completion and Licensure survey. Additional work on one half of the second floor and associated relocations of services remain. All bed floors have been completed and are in service.*

Saint Thomas Medical Center, CN1110-037A, has an outstanding certificate of need that will expire on March 1, 2017. The application was approved at the January 25, 2012 Agency meeting for the 3-phase hospital renewal project for various services and area: renovation of 89,134 SF of hospital space; construction an adjoined 6-level 135,537 SF patient tower; and the addition of a GE Discovery CT scanner. The estimated project cost is **$110,780,000.** *Project Status update: review of the 4/2/14 annual progress report revealed that Phase 1 of the project (renovations to the second floor ICU rooms) is 100% complete, with review by TDH occurring in March 2014. The OR renovations and Emergency Department CT are currently in construction ahead of schedule and are at 5% and 15% completion, respectively. Phase 2 work (new tower construction) is scheduled to begin mid/late-2014 and some Phase 3 work (reconfiguration of space that is not dependent on relocation of services to the new tower) is planned to start in the next several months. The overall*

project is expected to be complete in early 2017. Note: per clarification provided in the January 29, 2014 supplemental response for Saint Thomas Midtown Hospital, CN1401-001, four proposed ORs approved in CN1110-037A for the Saint Thomas West Hospital project could be eliminated if CN1401-001if necessary. An additional OR was eliminated in July 2013 upon completion of CN1103-010A for the conversion of two ORs to a cardiac OR.

Saint Thomas Hospital-Midtown, CN1401-001A, has an outstanding certificate of need that will expire on June 1, 2017. The application was approved at the April 23, 2014 Agency meeting for the development of a Joint Replacement Service by consolidating orthopedic operating rooms currently located on two different floors of STM and by relocating operating rooms (OR) at Saint Thomas West Hospital to STM. The service will contain ten (10) surgical joint replacement suites, PACU and Prep/Recovery private bay areas, and two (2) dedicated nursing units with a total of 62 private patient rooms. There will be no net increase to the OR complement of Saint Thomas Health – Nashville if the OR complement in Saint Thomas Hospital, CN110-037A is voluntarily reduced by 4 ORs. This project will not change the hospital's 683 licensed bed complement. The total estimated project cost is **$25,832,609.00.** *Project status update: this project was recently approved.*

PLEASE REFER TO THE REPORT BY THE DEPARTMENT OF HEALTH, DIVISION OF HEALTH STATISTICS, FOR A DETAILED ANALYSIS OF THE STATUTORY CRITERIA OF NEED, ECONOMIC FEASIBILITY, AND CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE IN THE AREA FOR THIS PROJECT. THAT REPORT IS ATTACHED TO THIS SUMMARY IMMEDIATELY FOLLOWING THE COLOR DIVIDER PAGE.

PAE/PJG (05/07/14)

EXHIBIT 1

The tables displayed below provide a breakout of the licensed bed inventory used to determine acute care bed need in Davidson and Wilson Counties for SMC's certificate of need application, CN1402-004. The licensed acute care beds by hospital were reported in the Licensed Facilities Report (April, 2014) and the most recent Joint Annual Report (CY2012). Both documents are published by the Tennessee Department of Health.

Table 1- Licensed Acute Care Bed Inventory in Summit Medical Center's Service Area

Acute Care Bed Inventory	General Hospital Beds	Rehab Beds	Long Term Acute Care Beds	Psychiatric Hospital Beds	Total Licensed Beds	Estimated Bed Need* (surplus)
2014 Licensed Facilities Report	4,033 beds (*see Table 2 below*)	111 beds Stallworth Nash Rehab	130 beds Select Specialty Kindred	None Included	4,274 beds	(1,328)
Used for acute care bed need formula?	Yes – 4,033 beds	No	No	No	4,033 beds	(1,087)

- *Note: estimate is based on the difference between # licensed beds (inventory) and an estimated need for 2,946 total beds in CY2018*

Table 2- Hospital Licensed Bed Inventory -SMC Application, CN1402-004

Hospital	2014 Beds – Licensed Facilities Report	2012 Beds – JAR	2012 Beds –as reported by applicant
Centennial	657	657	606
Metro Nashville	150	150	150
St Thomas-Midtown	683	683	683
St Thomas-West	541	541	541
Skyline-Nashville	213	213	213
Skyline-Madison	182	182	Not Reported
Southern Hills	126	132	120
Summit	188	188	188
Ctr for Spinal Surgery	23	23	23
Vanderbilt	1,025	985	916
Univ Medical Center	170	170	170
UMC-McFarland Rehab	75	75	Not Reported
Total	**4,033 beds**	**3,999 beds**	**3,610 beds**

Note: hospitals in table provide similar med/surg services to Summit Medical Center

LETTER OF INTENT

LETTER OF INTENT -- HEALTH SERVICES & DEVELOPMENT AGENCY

The Publication of Intent is to be published in the Tennessean, which is a newspaper of general circulation in Davidson County, Tennessee, on or before February 10, 2014, for one day.

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. Sections 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that TriStar Summit Medical Center (a hospital), owned and managed by HCA Health Services of Tennessee, Inc. (a corporation), intends to file an application for a Certificate of Need to convert existing space to eight (8) inpatient medical-surgical beds on the 7th floor of its facility at 5655 Frist Boulevard, Hermitage, TN 37076. The estimated capital cost is $1,850,000.

TriStar Summit Medical Center is a general hospital licensed by the Board for Licensing Health Care Facilities, Tennessee Department of Health, for 188 hospital beds. The project will increase its licensed hospital bed complement to 196 hospital beds. It will not initiate or discontinue any health service, or add any major medical equipment.

The anticipated date of filing the application is on or before February 14, 2014. The contact person for the project is John Wellborn, who may be reached at Development Support Group, 4219 Hillsboro Road, Suite 210, Nashville, TN 37215; (615) 665-2022.

John L Wellborn 2-7-14 jwdsg@comcast.net

(Signature) (Date) (E-mail Address)

ORIGINAL APPLICATION

DSG Development Support Group

FEB 14 '14 AM 8:3

February 13, 2014

Melanie Hill, Executive Director
Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

RE: CON Application Submittal
Summit Medical Center--Addition of Eight Beds in Existing 7th-Floor Space
Hermitage, Davidson County

Dear Mrs. Hill:

This letter transmits an original and two copies of the subject application. The affidavit and filing fee are enclosed.

I am the contact person for this project. Jerry Taylor is legal counsel. Please advise me of any additional information you may need. We look forward to working with the Agency on this project.

Respectfully,

John Wellborn

John Wellborn
Consultant

4219 Hillsboro Road, Suite 203
Nashville, TN 37215
jwdsg@comcast.net
Tel 615.665.2022
Fax 615.665.2042

SUPPLEMENTAL- # 1
February 21, 2014
3:50pm

PART A

1. Name of Facility, Agency, or Institution

Summit Medical Center		
Name		
5655 Frist Boulevard		Davidson
Street or Route		*County*
Hermitage	TN	37076
City	*State*	*Zip Code*

2. Contact Person Available for Responses to Questions

John Wellborn		Consultant	
Name		*Title*	
Development Support Group		jwdsg@comcast.net	
Company Name		*E-Mail Address*	
4219 Hillsboro Road, Suite 210	Nashville	TN	37215
Street or Route	*City*	*State*	*Zip Code*
CON Consultant	615-665-2022	615-665-2042	
Association With Owner	*Phone Number*	*Fax Number*	

3. Owner of the Facility, Agency, or Institution

HCA Health Services of Tennessee, Inc.		615-316-4902
Name		*Phone Number*
Same as in #1 above		
Street or Route		*County*
Hermitage	TN	37076
City	*State*	*Zip Code*

4. Type of Ownership or Control (Check One)

A. Sole Proprietorship		F. Government (State of TN or Political Subdivision)	
B. Partnership		G. Joint Venture	
C. Limited Partnership		H. Limited Liability Company	
D. Corporation (For-Profit)	x	I. Other (Specify):	
E. Corporation (Not-for-Profit)			

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS

5. *Name of Management/Operating Entity (If Applicable)* NA

Name		
Street or Route		*County*
City	*State*	*Zip Code*

6. *Legal Interest in the Site of the Institution (Check One)*

A. Ownership	x	D. Option to Lease	
B. Option to Purchase		E. Other (Specify):	
C. Lease of ____ Years			

7. *Type of Institution (Check as appropriate—more than one may apply)*

A. Hospital (Specify): General	x	I. Nursing Home	
B. Ambulatory Surgical Treatment Center (ASTC) Multi-Specialty		J. Outpatient Diagnostic Center	
C. ASTC, Single Specialty		K. Recuperation Center	
D. Home Health Agency		L. Rehabilitation Center	
E. Hospice		M. Residential Hospice	
F. Mental Health Hospital		N. Non-Residential Methadone	
G. Mental Health Residential Faclity		O. Birthing Center	
H. Mental Retardation Institutional Habilitation Facility (ICF/MR)		P. Other Outpatient Facility (Specify):	
		Q. Other (Specify):	

8. *Purpose of Review (Check as appropriate—more than one may apply*

A. New Institution		G. Change in Bed Complement Please underline the type of Change: Increase, Decrease, Designation, Distribution, Conversion, Relocation	x
B. Replacement/Existing Facility		H. Change of Location	
C. Modification/Existing Facility	x	I. Other (Specify):	
D. Initiation of Health Care Service as defined in TCA Sec 68-11-1607(4) (Specify)			
E. Discontinuance of OB Service			
F. Acquisition of Equipment			

9. *Bed Complement Data)*

(Please indicate current and proposed distribution and certification of facility beds.)

	Current Licensed Beds	CON approved beds (under construct.)	Staffed Beds	Beds Proposed (Change)	TOTAL Beds With Current & Proposed Project
A. Medical	118		118	+8	126
B. Surgical					
C. Long Term Care Hosp.					
D. Obstetrical	24		24		24
E. ICU/CCU	24		24		24
F. Neonatal	10		10		10
G. Pediatric					
H. Adult Psychiatric					
I. Geriatric Psychiatric					
J. Child/Adolesc. Psych.					
K. Rehabilitation	12		12		12
L. Nursing Facility (non-Medicaid certified)					
M. Nursing Facility Lev. 1 (Medicaid only)					
N. Nursing Facility Lev. 2 (Medicare only)					
O Nursing Facility Lev. 2 (dually certified for Medicare & Medicaid)					
P. ICF/MR					
Q. Adult Chemical Dependency					
R. Child/Adolescent Chemical Dependency					
S. Swing Beds					
T. Mental Health Residential Treatment					
U. Residential Hospice					
TOTAL	**188**		**188**	**+8**	**196**

10. Medicare Provider Number:	440150
Certification Type:	general hospital
11. Medicaid Provider Number:	44-0205
Certification Type:	general hospital

12. & 13. See page 4

A.12. IF THIS IS A NEW FACILITY, WILL CERTIFICATION BE SOUGHT FOR MEDICARE AND/OR MEDICAID?

This is an existing facility already certified for both programs. In CY2013, Summit Medical Center had an overall payor mix of 45.7% Medicare and 10.9% TennCare/Medicaid.

A.13. IDENTIFY ALL TENNCARE MANAGED CARE ORGANIZATIONS / BEHAVIORAL HEALTH ORGANIZATIONS (MCO'S/BHO'S) OPERATING IN THE PROPOSED SERVICE AREA. WILL THIS PROJECT INVOLVE THE TREATMENT OF TENNCARE PARTICIPANTS? Yes IF THE RESPONSE TO THIS ITEM IS YES, PLEASE IDENTIFY ALL MCO'S WITH WHICH THE APPLICANT HAS CONTRACTED OR PLANS TO CONTRACT.

DISCUSS ANY OUT-OF-NETWORK RELATIONSHIPS IN PLACE WITH MCO'S/BHO'S IN THE AREA.

Summit Medical Center is fully contracted with all available TennCare MCO's in the Middle Tennessee Region. They are as follows:

Table One: Contractual Relationships with Service Area MCO's	
Available TennCare MCO's	**Applicant's Relationship**
AmeriGroup	contracted
United Community Healthcare Plan (formerly AmeriChoice)	contracted
Select	contracted

SECTION B: PROJECT DESCRIPTION
B.I. PROVIDE A BRIEF EXECUTIVE SUMMARY OF THE PROJECT NOT TO EXCEED TWO PAGES. TOPICS TO BE INCLUDED IN THE EXECUTIVE SUMMARY ARE A BRIEF DESCRIPTION OF PROPOSED SERVICES AND EQUIPMENT, OWNERSHIP STRUCTURE, SERVICE AREA, NEED, EXISTING RESOURCES, PROJECT COST, FUNDING, FINANCIAL FEASIBILITY AND STAFFING.

Proposed Services and Equipment

- TriStar Summit Medical Center is a highly utilized 188-bed community hospital located beside I-40 in Hermitage, Tennessee, in far eastern Davidson County. It is the only general acute care hospital between downtown Nashville and Lebanon (in Wilson County).

- The hospital currently operates 110 medical-surgical beds and in March 2014 will open an additional 8 beds that were previously approved in 2013, for a total of 118 beds. This current project proposes to utilize a wing of the 7th floor that currently houses an outpatient sleep lab consisting of four sleep rooms, support space for the sleep lab, and offices. As a result of this request, Summit's bed license would increase from 188 to 196. The Sleep Lab will be relocated to the 4th floor of the medical office building attached to Summit's main campus. The Sleep Lab's capacity (4 rooms) will not change.

Ownership Structure

- TriStar Summit Medical Center is an HCA facility owned by HCA Health Services of Tennessee, Inc., whose ultimate parent company is HCA, Inc. Attachment A.4 contains details, an organization chart, and information on Tennessee facilities owned by HCA.

Service Area

- The project's primary service area will reflect the hospital's primary service area. That area consists of Davidson and Wilson Counties. Approximately 87.6% of Summit's admissions came from those two counties in 2013. No other county contributed as much as 2% of Summit's admissions.

Need

- In CY2012, medical-surgical bed average annual occupancy in 2012 was 83.4%.

- In CY 2013, Summit's medical-surgical bed occupancy averaged 87.5%.

- The eight approved orthopedic beds to open at Summit in the Spring of 2014, as part of a prior approved building project, will not fully relieve midweek occupancy pressures on medical-surgical beds. This proposed second 8-bed addition on the seventh floor is projected to relieve midweek occupancy pressures. It will be constructed in existing space, rather than by expensive new construction.

Existing Resources

• The most recent (2012) Joint Annual Reports indicated that there are 10 *general* hospital facilities in the two-county primary service area, with a total of 3,610 licensed beds. This excludes five facilities or campuses dedicated to psychiatric, rehabilitation, and long term acute care services.

• Summit is the only hospital on the eastern suburban edge of Davidson County, readily accessible to high-growth suburban communities in and around Hermitage and Mt. Juliet. It is a significant distance and drive time from the nearest hospitals east and west of it. It serves suburban patients and their physicians who do not want to make long drives to alternative acute care facilities.

Project Cost, Funding, Financial Feasibility, and Staffing

• The estimated cost of the project is $1,812,402 , all of which will be provided through a cash transfer from Summit's parent company, HCA.

• Summit's utilization ensures that the proposed beds will operate at high occupancy and with a positive financial margin.

• This small bed addition will require the addition of approximately 8.5 nurse and nurse tech FTE's.

B.II. PROVIDE A DETAILED NARRATIVE OF THE PROJECT BY ADDRESSING THE FOLLOWING ITEMS AS THEY RELATE TO THE PROPOSAL.

B.II.A. DESCRIBE THE CONSTRUCTION, MODIFICATION AND/OR RENOVATION OF THE FACILITY (EXCLUSIVE OF MAJOR MEDICAL EQUIPMENT COVERED BY T.C.A. 68-11-1601 *et seq.)* INCLUDING SQUARE FOOTAGE, MAJOR AREAS, ROOM CONFIGURATION, ETC.

Physical Description

The project will require renovation of the west wing of Summit Medical Center's seventh floor. The west wing as built was partitioned into space equivalent to patient room sizes, but has been used for Sleep Lab services in recent years. Those rooms provide overnight stays to evaluate sleep disorders, but they are not inpatient acute care beds; nor are they now licensed as such. Adding eight medical-surgical beds at that location will increase Summit's licensed bed complement by only 4.3%, from 188 to 196 beds. The seventh-floor work to be performed will consist of major and minor renovation in 4,406 SF of space, and will include adding handicapped-accessible bathrooms. A floor plan of the proposed renovation is provided on the second following page.

The Sleep Lab currently consists of four sleep rooms, support spaces for the sleep roooms, and offices. It will be relocated to medical office building space on the Summit campus, owned by Summit. It will require renovation of approximately 3,000 SF. Its capacity (four sleep rooms) will remain the same.

Table Two-A: Summary of Proposed Bed Changes			
	Current Licensed Beds	**Proposed Licensed Beds**	**Change in Licensed Beds**
Medical-Surgical	118	126	+8
Total Hospital	188	196	+8 (+4.3%)

Source: HCA Development Department

Table Two-B: Summary of Construction	
	Total Square Feet
Area of New Construction	0
Area of Renovation--Seventh Floor Beds	4,406 SF
Area of Renovation--MOB (Sleep Lab)	3,000 SF*
Total Area of Construction	7,406 SF

Source: HCA Development Department. Sleep lab will have 2,936 usable SF.

Operational Schedule

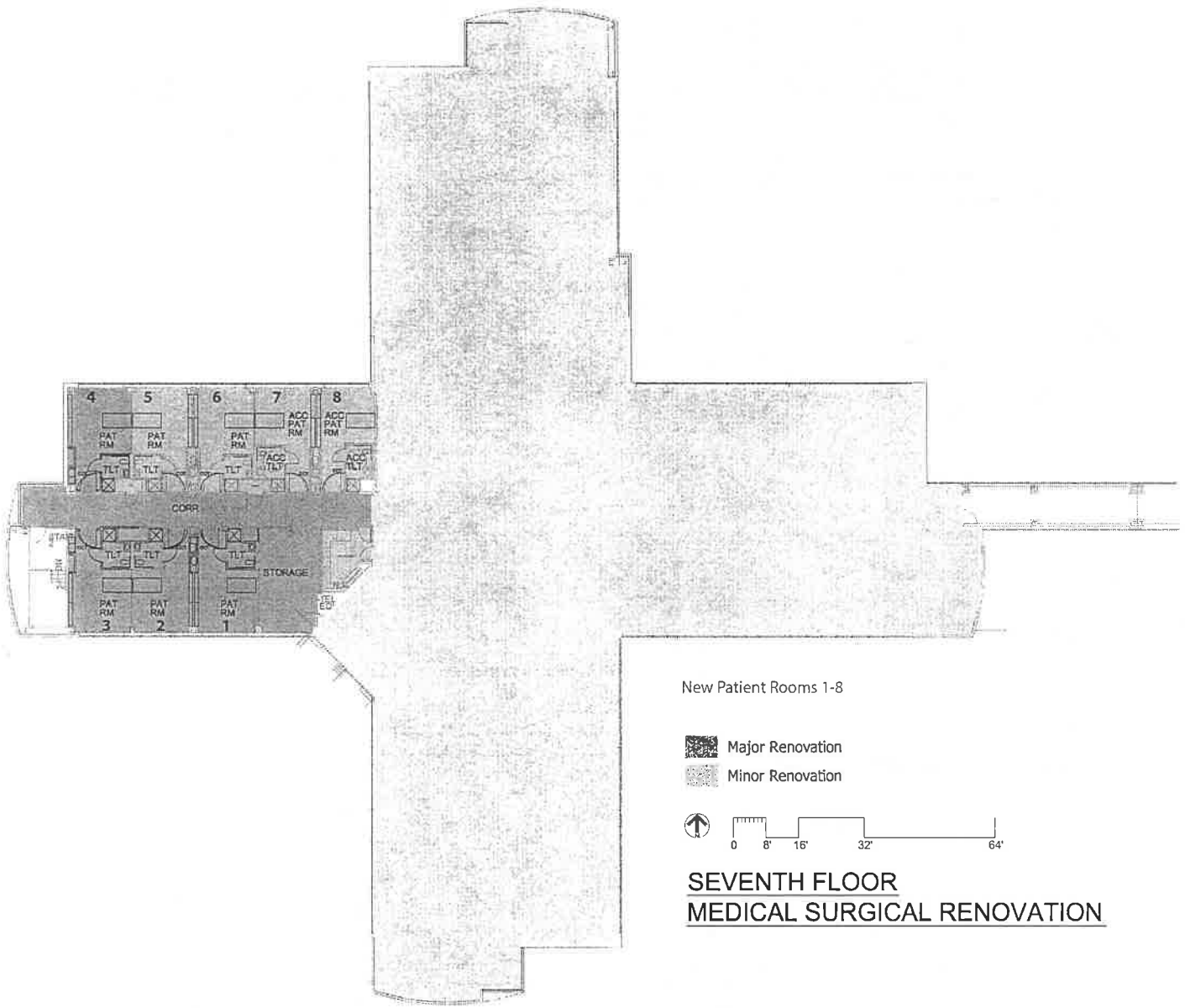
The eight beds will be available for acute inpatient medical-surgical care 24 hours daily, throughout the year. The applicant intends to open them on or before January 1, 2015. CY2015 is their projected first full year of operation. The Sleep Lab will continue to be available during normal operating hours, Monday through Friday.

Cost and Funding

The project cost is estimated at $1,812,402. This will be funded entirely by HCA, Inc., TriStar Summit Medical Center's ultimate parent company, through a cash transfer to TriStar Health System, HCA's regional office.

Ownership

Summit Medical Center is owned and operated by HCA Health Services of Tennessee, Inc., which is wholly owned through entities wholly owned by HCA, Inc., a national hospital company based in Nashville, Tennessee. Attachment A.4 contains an organization chart of the applicant's chain of ownership up to the parent company.



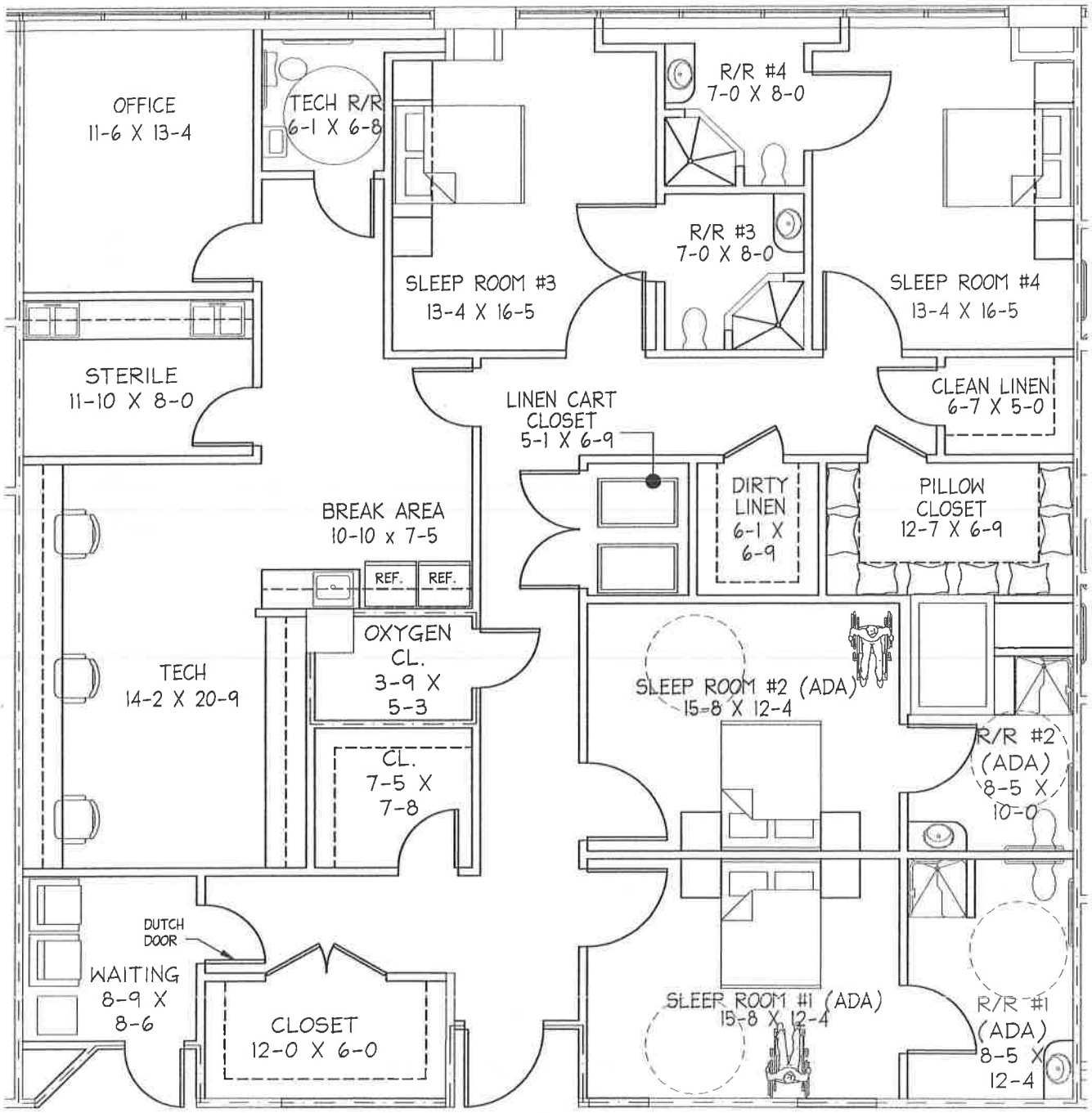
SEVENTH FLOOR
MEDICAL SURGICAL RENOVATION

TriStar Summit Medical Center
Hermitage, TN

Seventh Floor | Proposed
MED SURG

G S & P

PROJECT No.
29963.00
January 6, 2014



SUMMIT SLEEP LAB
PRELIMINARY 1 - 2,936 U.S.F.

ARCHITECTURAL ENVIRONMENTS

FILE: AE14-001
SCALE: ⅛" = 1'-0"
2,936 U.S.F.

N

SUMMIT MOB I
5651 FRIST BLVD.
HERMITAGE, TENNESSEE

9010 OVERLOOK BLVD. SUITE C-3 . BRENTWOOD, TN T - 615-620-4420 F - 615-620-4425 . www.aeenvirons.com

APPLICANTS WITH HOSPITAL PROJECTS (CONSTRUCTION COST IN EXCESS OF $5 MILLION) AND OTHER FACILITY PROJECTS (CONSTRUCTION COST IN EXCESS OF $2 MILLION) SHOULD COMPLETE THE SQUARE FOOTAGE AND COSTS PER SQUARE FOOTAGE CHART...

Not applicable; the project cost is below that review threshold.

PLEASE ALSO DISCUSS AND JUSTIFY THE COST PER SQUARE FOOT FOR THIS PROJECT.

The estimated $1,163,133 renovation cost of the project is approximately $157 per SF--with the bed wing averaging approximately $224 PSF, and the Sleep Lab MOB renovation averaging approximately $59 PSF (these are rounded numbers).

Table Two: Construction Cost PSF			
Component	**Construction Cost**	**SF of Renovation**	**Construction Cost PSF**
7th Floor Beds	$984,973	4,406	$223.55
Sleep Lab	$176,160	3,000	$58.72
Total Project	*$1,161,133*	*7,406*	*$156.78*

The 2010-12 hospital construction projects approved by the HSDA had the following costs per SF. The Summit project's bed wing construction cost of approximately $224 PSF is below the 3rd quartile average Statewide. The project's overall total construction cost average of approximately $157 PSF is below the Statewide median.

Table Three: Hospital Construction Cost Per Square Foot Applications Approved by the HSDA Years: 2010 – 2012			
	Renovation	**New Construction**	**Total Construction**
1st Quartile	$99.12/sq ft	$234.64/sq ft	$167.99/sq ft
Median	$177.60/sq ft	$259.66/sq ft	$235.00/sq ft
3rd Quartile	$249.00/sq ft	$307.80/sq ft	$274.63/sq ft

Source: Health Services and Development Agency website, 2014

IF THE PROJECT INVOLVES NONE OF THE ABOVE, DESCRIBE THE DEVELOPMENT OF THE PROPOSAL.

Not applicable.

B.II.B. IDENTIFY THE NUMBER AND TYPE OF BEDS INCREASED, DECREASED, CONVERTED, RELOCATED, DESIGNATED, AND/OR REDISTRIBUTED BY THIS APPLICATION. DESCRIBE THE REASONS FOR CHANGE IN BED ALLOCATIONS AND DESCRIBE THE IMPACT THE BED CHANGE WILL HAVE ON EXISTING SERVICES.

Table Four: Proposed Changes in Assignment of Licensed Hospital Beds at Summit Medical Center

Bed Type	Current Bed Assignment (Approved Complements)	Proposed Bed Assignment (Change)
General Medical-Surgical	118 (includes 8 beds to be operational* in March 2014)	126 (+8)
Critical Care	24	24
NICU	10	10
Obstetrics	24	24
Rehabilitation	12	12
Total Licensed Beds	188	196 (+8)

Source: Hospital Management

**This 8-bed surgical unit for the Joint Replacement program has been constructed; and it received TDH occupancy approval in late January 2014. However, it will not open until March 2014 due to delays in equipment delivery. It is listed in Part A as existing licensed beds.*

B.II.C. AS THE APPLICANT, DESCRIBE YOUR NEED TO PROVIDE THE FOLLOWING HEALTH CARE SERVICES (IF APPLICABLE TO THIS APPLICATION):

1. **ADULT PSYCHIATRIC SERVICES**
2. **ALCOHOL AND DRUG TREATMENT ADOLESCENTS >28 DAYS**
3. **BIRTHING CENTER**
4. **BURN UNITS**
5. **CARDIAC CATHETERIZATION SERVICES**
6. **CHILD AND ADOLESCENT PSYCHIATRIC SERVICES**
7. **EXTRACORPOREAL LITHOTRIPSY**
8. **HOME HEALTH SERVICES**
9. **HOSPICE SERVICES**
10. **RESIDENTIAL HOSPICE**
11. **ICF/MR SERVICES**
12. **LONG TERM CARE SERVICES**
13. **MAGNETIC RESONANCE IMAGING (MRI)**
14. **MENTAL HEALTH RESIDENTIAL TREATMENT**
15. **NEONATAL INTENSIVE CARE UNIT**
16. **NON-RESIDENTIAL METHADONE TREATMENT CENTERS**
17. **OPEN HEART SURGERY**
18. **POSITIVE EMISSION TOMOGRAPHY**
19. **RADIATION THERAPY/LINEAR ACCELERATOR**
20. **REHABILITATION SERVICES**
21. **SWING BEDS**

Need for More Medical-Surgical Beds at Summit Medical Center

In July 2013, the HSDA approved Summit's application CN1304-011, for addition of twelve rehabilitation beds and formation of an eight-bed orthopedic surgical bed unit specifically for a new Joint Replacement program. The twelve rehabilitation beds were opened six months later, on December 26, 2013. The eight-bed Joint Replacement unit is under construction and is expected to open during March, 2014. Neither of those changes will increase Summit's 188-bed license, because they are being offset by closure of twenty psychiatric beds.

However, even with the eight Joint Replacement beds in service, Summit will still have a current need for additional bed capacity for *medical* admissions, especially on the 7th Floor, where cardiology, neurology, and stroke patients receive care. As Summit projected to the HSDA in that prior application, even with the eight new orthopedic beds in service, its medical-surgical complement (118) would still reach 85% *average* annual occupancy in CY2015. An 85% average annual occupancy means that during the middle

of the week, when patient census is highest in medical-surgical units, occupancy of beds will be higher than 85%. And on weekends it will be lower than 85%.

The need is visually demonstrated by Figure One on the following page. It shows Summit's actual CY2012 and CY2013 medical-surgical inpatient census, plotted against 85% occupancy for three different bed capacity scenarios:

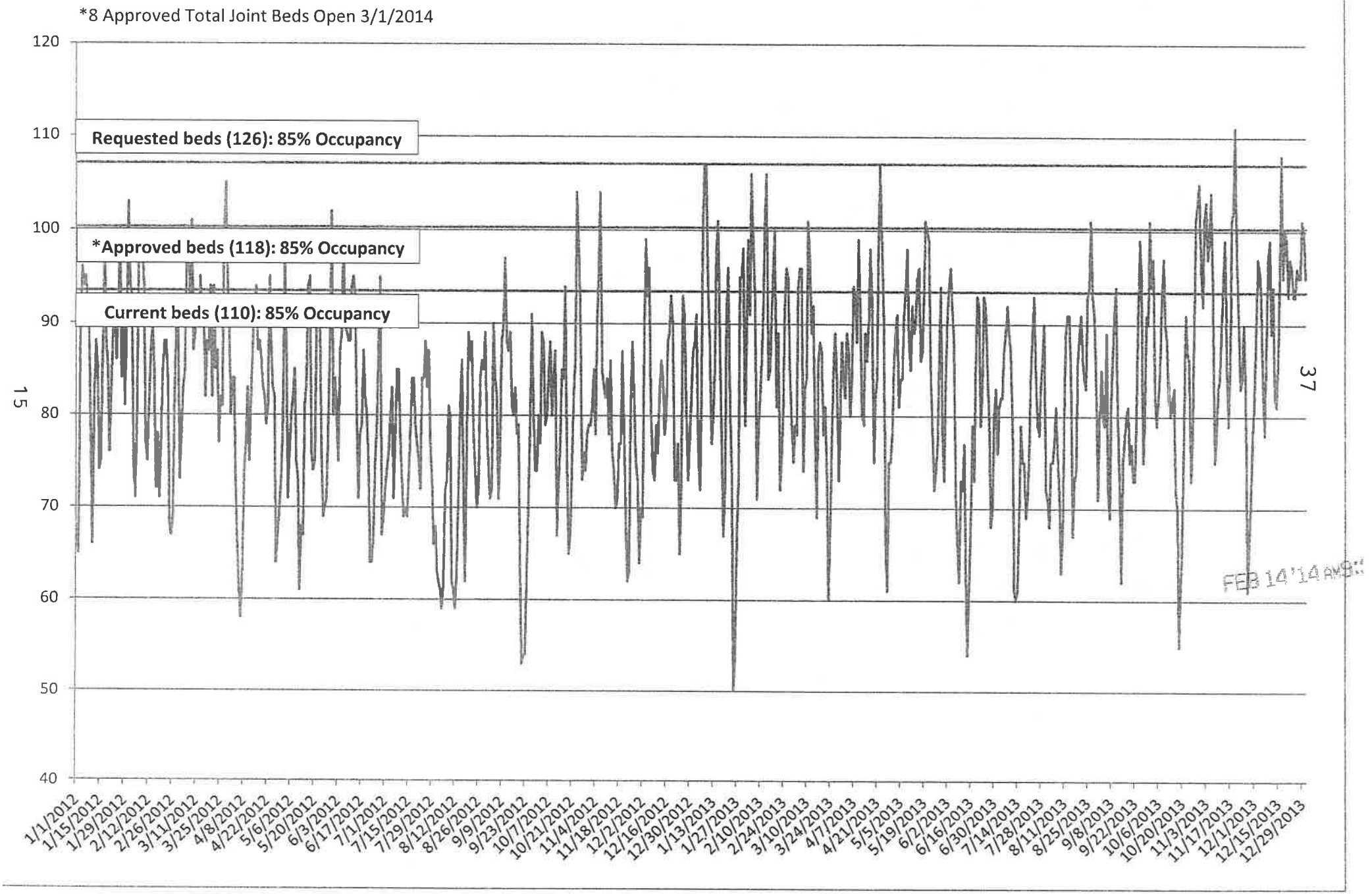
(a) 110 medical-surgical beds, the current medical-surgical bed complement for many years;
(b) 118 medical-surgical beds, the complement to be available in March, 2014 when the eight-bed Joint Replacement unit opens; and
(c) 126 medical-surgical beds, the complement proposed in this application for the west wing of the seventh floor.

The lowest line (110 beds) demonstrates that last year's approved CN1304-011 was appropriate to address chronically excessively high occupancy spikes mid-week. During 2012, medical-surgical bed occupancy reached or exceeded 85% on 45 days. During 2013, it met or exceeded 85% on 96 days.

The middle line (118 beds) illustrates that even the eight additional Joint Replacement Beds will not eliminate frequent mid-week surges of occupancies above 80% to 85%. There will still be many times when new patients must be held waiting in the ED, the Post-Anesthesia Care Unit (recovery beds) or even the ICU, until beds become available. That is inappropriate and inefficient.

Third, the occupancy line for the proposed 126 medical-surgical beds shows that 126 beds are appropriate even if Summit's CY2015 admissions were to remain level after CY2013 (which is unlikely). The additional seventh-floor beds being requested for medical admissions will result in more manageable and efficient utilization mid-week, reducing the times that patients needing beds are kept waiting in the Emergency Room, the PACU (Recovery), or ICU.

Figure One: TriStar Summit Medical Center
Historical MedSurg Daily Census w/ Current & Future Occupancy
2012-2013



No Reasonable Alternatives at Other Hospitals in the Primary Service Area

While there are some underutilized hospital beds reported in Davidson County and Wilson County, the applicant does not regard them as viable options for residents of high-growth suburbs. Several factors should be considered.

First, Summit is in Hermitage, in far eastern Davidson County. It is an *average* of almost 30 miles and 39 minutes' *round trip* drive to and from alternative hospitals in its primary service area. That is too long a travel time for many suburban families who need to travel to and from hospitalized family members every day. Summit Medical Center was originally approved so that Hermitage area residents would not be forced into such long travel times to older hospitals. The same is true of all the suburban hospitals ringing the Nashville metropolitan area. As Nashville's population grows and its traffic increases, the need to widely distribute beds to suburban growth areas of the city also increases. The CON Board has historically recognized this need, by repeatedly approving expansions of services and beds at suburban hospitals.

Second, Summit estimates that approximately 80% of its admitting physicians now practice primarily or almost exclusively at Summit. Most cannot practice productively at multiple hospitals that are a long drive from Summit. It is problematic to ask unwilling patients to change physicians or service sites, simply to be able to fill up distant hospital beds. So there is a need to maintain reasonable bed availability in Hermitage, for those patients whose physicians can care for them only at Summit. While many patients can wait for an admission, many others cannot--for example, many medical patients and those with emergency surgeries. Suburban bed need should be locally met.

B.II.D. DESCRIBE THE NEED TO CHANGE LOCATION OR REPLACE AN EXISTING FACILITY.

Not applicable. The project does neither of those things.

B.II.E. DESCRIBE THE ACQUISITION OF ANY ITEM OF MAJOR MEDICAL EQUIPMENT (AS DEFINED BY THE AGENCY RULES AND THE STATUTE) WHICH EXCEEDS A COST OF $1.5 MILLION; AND/OR IS A MAGNETIC RESONANCE IMAGING SCANNER (MRI), POSITRON EMISSION TOMOGRAPHY (PET) SCANNER, EXTRACORPOREAL LITHOTRIPTER AND/OR LINEAR ACCELERATOR BY RESPONDING TO THE FOLLOWING:

1. For fixed site major medical equipment (not replacing existing equipment):
- **a. Describe the new equipment, including:**
  1. **Total Cost (As defined by Agency Rule);**
  2. **Expected Useful Life;**
  3. **List of clinical applications to be provided; and**
  4. **Documentation of FDA approval.**
- **b. Provide current and proposed schedule of operations.**

2. For mobile major medical equipment:
- **a. List all sites that will be served;**
- **b. Provide current and/or proposed schedule of operations;**
- **c. Provide the lease or contract cost;**
- **d. Provide the fair market value of the equipment; and**
- **e. List the owner for the equipment.**

3. Indicate applicant's legal interest in equipment (e.g., purchase, lease, etc.) In the case of equipment purchase, include a quote and/or proposal from an equipment vendor, or in the case of an equipment lease provide a draft lease or contract that at least includes the term of the lease and the anticipated lease payments.

Not applicable. There is no major medical equipment proposed in this project.

B.III.A. ATTACH A COPY OF THE PLOT PLAN OF THE SITE ON AN 8-1/2" X 11" SHEET OF WHITE PAPER WHICH MUST INCLUDE:
1. **SIZE OF SITE (IN ACRES);**
2. **LOCATION OF STRUCTURE ON THE SITE;**
3. **LOCATION OF THE PROPOSED CONSTRUCTION; AND**
4. **NAMES OF STREETS, ROADS OR HIGHWAYS THAT CROSS OR BORDER THE SITE.**

PLEASE NOTE THAT THE DRAWINGS DO NOT NEED TO BE DRAWN TO SCALE. PLOT PLANS ARE REQUIRED FOR ALL PROJECTS.

See Attachment B.III.A.

B.III.B.1. DESCRIBE THE RELATIONSHIP OF THE SITE TO PUBLIC TRANSPORTATION ROUTES, IF ANY, AND TO ANY HIGHWAY OR MAJOR ROAD DEVELOPMENTS IN THE AREA. DESCRIBE THE ACCESSIBILITY OF THE PROPOSED SITE TO PATIENTS/CLIENTS.

Summit Medical Center is located in Hermitage, on the far eastern edge of Davidson County near the Wilson County line. The hospital is on the west side of Old Hickory Boulevard / Highway 45, approximately one mile north of Exit 221 from I-40, and is visible from that exit. Summit serves patients primarily from eastern Davidson County and western Wilson County. Interstate I-40 and U.S. Highway 70, which run east and west between Nashville and Lebanon, are the service area's principal east-west roadways; Old Hickory Boulevard is one of the service area's major roadways running north-south beside the Summit campus.

Summit is very accessible to western Wilson County, as well as to eastern Davidson County between Old Hickory Lake (the Cumberland River) and the areas west, north, and east of Percy Priest Lake. The rapidly growing Mt. Juliet community is the fastest growing sector of western Wilson County; and Mt. Juliet is much closer to Summit Medical Center (6.9 miles; 15 minutes) than it is to University Medical Hospital in Lebanon (13.2 miles; 19 minutes).

Table Five: Round-Trip Mileage and Drive Times Between Hermitage and Other Medical-Surgical Beds In the Primary Service Area

Location of Medical-Surgical Beds	Mileage 1-Way	Time 1-Way	Mileage Rd-Trip	Time Rd-Trip
Centennial Medical Center	13.6	19 min.	27.2	38 min.
Metro NV General Hospital	13.8	19 min.	27.6	38 min.
Saint Thomas Midtown Hospital	13.1	17 min.	26.2	34 min.
Saint Thomas West Hospital	16.8	21 min.	33.6	42 min.
Skyline Medical Center, Nashville	16.8	20 min.	17.5	40 min.
Southern Hills Medical Center	11.1	18 min.	22.2	36 min.
The Center for Spinal Surgery	13.3	18 min.	26.6	36 min
Vanderbilt Medical Center	13.4	18 min.	26.8	36 min.
University Medical Center (UMC)	21.5	24 min.	43.0	48 min
Averages	**14.8 mi.**	**19.3 min.**	**29.6 mi.**	**38.7 min.**

Source: Google Maps, January 2014. All facilities are in Davidson County, except UMC, which is in Lebanon, Wilson County.

B.IV. ATTACH A FLOOR PLAN DRAWING FOR THE FACILITY WHICH INCLUDES PATIENT CARE ROOMS (NOTING PRIVATE OR SEMI-PRIVATE), ANCILLARY AREAS, EQUIPMENT AREAS, ETC.

See attachment B.IV.

IV. FOR A HOME CARE ORGANIZATION, IDENTIFY

1. **EXISTING SERVICE AREA (BY COUNTY);**
2. **PROPOSED SERVICE AREA (BY COUNTY);**
3. **A PARENT OR PRIMARY SERVICE PROVIDER;**
4. **EXISTING BRANCHES AND/OR SUB-UNITS; AND**
5. **PROPOSED BRANCHES AND/OR SUBUNITS.**

Not applicable. The application is not for a home care organization.

C(I) NEED

C(I).1. DESCRIBE THE RELATIONSHIP OF THIS PROPOSAL TO THE IMPLEMENTATION OF THE STATE HEALTH PLAN AND TENNESSEE'S HEALTH: GUIDELINES FOR GROWTH.

A. PLEASE PROVIDE A RESPONSE TO EACH CRITERION AND STANDARD IN CON CATEGORIES THAT ARE APPLICABLE TO THE PROPOSED PROJECT. DO NOT PROVIDE RESPONSES TO GENERAL CRITERIA AND STANDARDS (PAGES 6-9) HERE.

B. APPLICATIONS THAT INCLUDE A CHANGE OF SITE FOR A HEALTH CARE INSTITUTION, PROVIDE A RESPONSE TO GENERAL CRITERION AND STANDARDS (4)(a-c).

Project-Specific Review Criteria--Acute Care Bed Services

From an areawide planning standpoint, this project adds a negligible number of acute care beds. It increases service area's acute care beds by only 8 beds--an insignificant change of one-fifth of one percent of the service area's total 3,999 licensed hospital beds (all licensed acute care beds), and three-fourths of 1% of the bed surplus projected by the Department of Health for CY 2018.

1. The following methodology should be used and the need for hospital beds should be projected four years into the future from the current year...(guidelines detail the steps of the bed need projection methodology; see pp. 15-16 of Guidelines for Growth.)

The Tennessee Department of Health's most recently issued bed need projection (for 2014-2018) is provided following this response. It indicates a surplus of 1,053 acute care hospital beds of all types in the project's service area, Davidson and Wilson Counties. This project would increase the surplus by approximately three-fourths of one percent.

Table Six: Minimal Impact of Eight Additional Beds On Service Area Hospital Bed Complements

	Licensed Beds	Bed Surplus 2018	Proposed New Beds	% of Licensed Beds	% of Bed Surplus
Davidson Co.	3,754	940	+8	less than ¼ of 1%	less than 1%
Wilson Co.	245	113	0	0	0
Primary Service Area	3,999	1,053	+8	1/5 of 1%	3/4 of 1%

Source: TN Department of Health Hospital Bed Need Projection, 2014-2018.

ACUTE-CARE BED NEED PROJECTIONS FOR 2014 AND 2018, BASED ON FINAL 2012 HOSPITAL JARS

COUNTY	2012		CURRENT	SERVICE AREA POPULATION			PROJECTED		PROJECTED		2012 ACTUAL BEDS		SHORTAGE/SURPLUS	
	INPATIENT DAYS	ADC	NEED	2012	2014	2018	ADC-2014	NEED 2014	ADC-2018	NEED 2018	LICENSED	STAFFED	LICENSED	STAFFED
Anderson	47,731	131	164	94,639	95,470	97,048	132	165	134	168	301	255	-133	-87
Beford	7,281	20	30	17,853	18,323	19,505	20	31	22	33	60	60	-27	-27
Benton	1,959	5	11	2,278	2,264	2,243	5	11	5	11	25	12	-14	-1
Bledsoe	2,984	8	15	2,088	2,078	2,085	8	15	8	15	25	25	-10	-10
Blount	51,235	140	176	97,454	99,770	104,941	144	180	151	189	304	238	-115	-49
Bradley	38,232	105	131	82,623	84,112	87,052	107	133	110	138	351	207	-213	-69
Campbell	18,681	51	68	21,557	21,827	22,326	52	69	53	70	120	97	-50	-27
Cannon	6,638	18	28	3,813	3,874	3,969	18	29	19	29	60	50	-31	-21
Carroll	6,718	18	28	14,137	14,118	14,111	18	28	18	28	115	68	-87	-40
Carter	15,622	43	58	29,978	30,095	30,448	43	58	43	59	121	79	-62	-20
Cheatham	1,549	4	9	1,364	1,381	1,413	4	9	4	9	12	12	-3	-3
Chester	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Claiborne	7,878	22	32	12,643	12,753	13,009	22	33	22	33	85	39	-52	-6
Clay	5,592	15	24	5,364	5,343	5,345	15	24	15	24	36	34	-12	-10
Cocke	7,541	21	31	16,066	16,425	17,225	21	32	22	33	74	36	-41	-3
Coffee	31,305	86	107	56,704	57,545	59,957	87	109	91	113	214	159	-101	-46
Crockett	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Cumberland	21,801	60	78	45,561	46,213	48,038	61	79	63	81	189	123	-108	-42
Davidson	763,385	2,092	2,614	1,451,264	1,488,518	1,562,068	2,145	2,681	2,251	2,814	3,754	3,129	-940	-314
Decatur	3,411	9	16	5,011	5,052	5,157	9	17	10	17	40	27	-23	-16
DeKalb	4,110	11	19	7,665	7,707	7,805	11	19	12	19	71	56	-52	-37
Dickson	18,017	49	66	33,604	33,850	34,413	50	66	51	67	157	120	-90	-53
Dyer	12,937	35	49	33,319	33,224	33,183	35	49	35	49	225	120	-176	-71
Fayette	714	2	5	2,325	2,406	2,603	2	5	2	6	46	10	-40	-4
Fentress	0	0	0	.	.	.	.	.	.	.	85	54	.	.
Franklin	22,404	61	80	33,182	33,338	33,983	62	80	63	81	152	110	-71	-29
Gibson	5,069	14	23	7,947	8,051	8,206	14	23	14	23	209	90	-186	-67
Giles	9,124	25	37	12,333	12,327	12,331	25	37	25	37	95	81	-58	-44
Grainger	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Greene	27,601	76	96	50,076	50,565	51,689	76	97	78	99	240	170	-141	-71
Grundy	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Hamblen	39,464	108	135	76,894	77,909	80,095	110	137	113	141	302	212	-161	-71
Hamilton	392,786	1,076	1,345	696,028	710,184	736,123	1,098	1,372	1,138	1,423	1,551	1,235	-128	188
Hancock	1,229	3	8	1,661	1,655	1,652	3	8	3	8	10	10	-2	-2
Hardeman	815	2	6	2,537	2,508	2,480	2	6	2	6	51	23	-45	-17
Hardin	7,103	20	30	14,725	14,795	14,963	20	30	20	30	58	49	-28	-19
Hawkins	3,542	10	17	10,354	10,441	10,555	10	17	10	17	50	46	-33	-29
Haywood	1,617	4	9	3,872	3,831	3,811	4	9	4	9	62	36	-53	-27
Henderson	2,444	7	13	6,143	6,182	6,284	7	13	7	13	45	45	-32	-32
Henry	16,775	46	62	28,422	28,546	28,712	46	62	46	62	142	101	-80	-39
Hickman	492	1	4	1,425	1,427	1,444	1	4	1	4	15	15	-11	-11
Houston	2,870	8	14	4,017	4,052	4,109	8	15	8	15	25	25	-10	-10
Humphreys	1,697	5	10	3,463	3,466	3,477	5	10	5	10	25	25	-15	-15

ACUTE-CARE BED NEED PROJECTIONS FOR 2014 AND 2018, BASED ON FINAL 2012 HOSPITAL JARS

COUNTY	2012		CURRENT	SERVICE AREA POPULATION			PROJECTED		PROJECTED		2012 ACTUAL BEDS		SHORTAGE/SURPLUS	
	INPATIENT DAYS	ADC	NEED	2012	2014	2018	ADC-2014	NEED 2014	ADC-2018	NEED 2018	LICENSED	STAFFED	LICENSED	STAFFED
Union	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Van Buren	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Warren	11,619	32	45	21,743	21,931	22,287	32	45	33	46	125	48	-79	-2
Washington	167,908	460	575	202,955	206,820	214,435	469	586	486	608	581	581	27	27
Wayne	1,990	6	11	4,701	4,683	4,647	5	11	5	11	80	32	-69	-21
Weakley	6,398	18	27	17,299	17,478	17,808	18	27	18	28	100	65	-72	-37
White	7,122	20	30	10,543	10,722	11,141	20	30	21	31	60	44	-29	-13
Williamson	31,464	86	108	99,271	103,289	111,805	90	112	97	121	185	185	-64	-64
Wilson	34,781	95	119	56,265	58,335	62,267	99	124	105	132	245	245	-113	-113

Source: Tennessee Department of Health, Division of Policy, Planning and Assessment, Office of Health Statistics. 11/14/2013

Data from Final JAR-Hospitals Schedules F and G. Underlying Tennessee population estimates and projections (2013 Series) from Office of Health Statistics. Projections and estimates for other states obtained from those states.

2. New hospital beds can be approved in excess of the "need standard for a county" if the following criteria are met:

a) All existing hospitals in the projected service area have an occupancy level greater than or equal to 80% for the most recent joint annual report. Occupancy should be based on the number of licensed beds rather than on staffed beds.

b) All outstanding new acute care bed CON projects in the proposed service area are licensed.

c) The Health Facilities Agency may give special consideration to acute care bed proposals for specialty health service units in tertiary care regional referral hospitals.

None of these exceptions applies to this project. Areawide hospital bed occupancy at the area's general hospitals, as reported in their 2012 Joint Annual Reports, averaged below 80%. Vanderbilt Medical Center has had major bed additions approved since 2007, which are not fully implemented. The applicant is not a tertiary care regional referral hospital.

The Framework for Tennessee's Comprehensive State Health Plan
Five Principles for Achieving Better Health

The following Five Principles for Achieving Better Health serve as the basic framework for the State Health Plan. After each principle, the applicant states how this CON application supports the principle, if applicable.

1. Healthy Lives

The purpose of the State Health Plan is to improve the health of Tennesseans.
Every person's health is the result of the interaction of individual behaviors, society, the environment, economic factors, and our genetic endowment. The State Health Plan serves to facilitate the collaboration of organizations and their ideas to help address health at these many levels.

This project will enable Summit Medical Center to continue to assure appropriate medical and surgical intervention for patients residing in its suburban service area, where those patients would have difficulty utilizing another hospital without changing their physician, and without driving long distances.

2. Access to Care

Every citizen should have reasonable access to health care.
Many elements impact one's access to health care, including existing health status, employment, income, geography, and culture. The State Health Plan can provide standards for reasonable access, offer policy direction to improve access, and serve a coordinating role to expand health care access.

Summit was originally approved, and has since grown, to be the primary hospital resource for large numbers of residents of a high-growth suburban area in eastern Davidson and western Wilson Counties. The incremental addition of beds to improve these persons' convenient access to care is appropriate under this criterion of the Plan.

3. Economic Efficiencies

The state's health care resources should be developed to address the needs of Tennesseans while encouraging competitive markets, economic efficiencies and the continued development of the state's health care system. **The State Health Plan should work to identify opportunities to improve the efficiency of the state's health care system and to encourage innovation and competition.**

This project increases hospital choice for area patients, because without these beds it would become very difficult for all persons needing local hospitalization to achieve it,

during periods of high demand. It is efficient to use existing rooms to meet this need, since they are available. It is efficient for patients and their families not to have commute to other hospital locations for care they want to obtain locally. It encourages competition by allowing Summit to have sufficient beds to meet the needs of persons wanting to choose Summit for their care.

4. Quality of Care

Every citizen should have confidence that the quality of health care is continually monitored and standards are adhered to by health care providers. **Health care providers are held to certain professional standards by the state's licensure system. Many health care stakeholders are working to improve their quality of care through adoption of best practices and data-driven evaluation.**

TriStar hospitals such as Summit Medical Center pursue and maintain high quality standards in their services, as defined by best practices standards within HCA as well as by standards promulgated by State licensure.

5. Health Care Workforce

The state should support the development, recruitment, and retention of a sufficient and quality health care workforce. **The state should consider developing a comprehensive approach to ensure the existence of a sufficient, qualified health care workforce, taking into account issues regarding the number of providers at all levels and in all specialty and focus areas, the number of professionals in teaching positions, the capacity of medical, nursing, allied health and other educational institutions, state and federal laws and regulations impacting capacity programs, and funding.**

This project will not affect the health care workforce to any significant degree.

C(I).2. DESCRIBE THE RELATIONSHIP OF THIS PROJECT TO THE APPLICANT'S LONG-RANGE DEVELOPMENT PLANS, IF ANY.

As stated, this project continues to implement HCA TriStar's plan to provide needed acute care services to suburban locations close to many patients' homes, as well as at its Centennial Medical Center tertiary referral hospital in central Davidson County.

C(I).3. IDENTIFY THE PROPOSED SERVICE AREA AND JUSTIFY THE REASONABLENESS OF THAT PROPOSED AREA. SUBMIT A COUNTY-LEVEL MAP INCLUDING THE STATE OF TENNESSEE CLEARLY MARKED TO REFLECT THE SERVICE AREA. PLEASE SUBMIT THE MAP ON A 8-1/2" X 11" SHEET OF WHITE PAPER MARKED ONLY WITH INK DETECTABLE BY A STANDARD PHOTOCOPIER (I.E., NO HIGHLIGHTERS, PENCILS, ETC.).

Summit Medical Center receives approximately 87.6% of its admissions from Davidson and Wilson Counties. On a sub-county level, Summit receives most of its admissions from eastern Davidson County and western Wilson County. Table Seven below mirrors the medical-surgical patient origin experience of the hospital in CY2013.

A service area map and a map showing the location of the service within the State of Tennessee are provided as Attachments C, Need--3 at the back of the application.

Table Seven: Projected Patient Origin
Summit Medical Center Medical-Surgical Admissions To Proposed Eight Beds

PSA County	Percent of Total	Yr. 1 Admissions	Yr. 2 Admissions
Davidson	58.4%	82	111
Wilson	29.2%	41	56
PSA Subtotal	**87.6%**	**123**	**167**
Other Counties or States (2% each)	12.4%	17	23
Total	**100.0%**	**140**	**190**

Source: Applicant's CY2013 records.

C(I).4.A DESCRIBE THE DEMOGRAPHICS OF THE POPULATION TO BE SERVED BY THIS PROPOSAL.

Please refer to Table Eight on the following page. The county-based primary service area is increasing in population. The State projects that the total population will increase by 4.5% between 2014 and 2018, compared to 3.7% for the State in that period. The elderly 65+ population will increase by 13.2%, compared to 16.1% for the State in that period. The primary service area's income, poverty and TennCare profiles differ somewhat from the State average, with Wilson County being significantly higher in household income, and significantly lower in poverty rate, and TennCare enrollment percentages, than Davidson County.

Table Eight (Revised): Demographic Characteristics of Primary Service Area Counties Summit Medical Center 2014-2018

Demographic	Davidson County	Wilson County	PRIMARY SERVICE AREA	STATE OF TENNESSEE
Median Age-2010 US Census	33.9	39.3	36.6	38.0
Total Population-2014	656,385	124,073	780,458	6,588,698
Total Population-2018	682,330	133,357	815,687	6,833,509
Total Population-% Change 2014 to 2018	4.0%	7.5%	4.5%	3.7%
Age 65+ Population-2014	74,375	17,944	92,319	981,984
% of Total Population	11.3%	14.5%	11.8%	14.9%
Age 65+ Population-2018	85,594	21,745	107,339	1,102,413
% of Population	12.5%	16.3%	13.2%	16.1%
Age 65+ Population- % Change 2014-2018	15.1%	21.2%	16.3%	12.3%
Median Household Income	$46,676	$61,353	$54,015	$44,140
TennCare Enrollees (9/13)	119,726	14,575	134,301	1,198,663
Percent of 2013 Population Enrolled in TennCare	18.2%	11.7%	17.2%	18.2%
Persons Below Poverty Level (2014)	121,431	11,539	132,970	1,139,845
Persons Below Poverty Level As % of Population (US Census)	18.5%	9.3%	17.0%	17.3%

Sources: TDH Population Projections, May 2013; U.S. Census QuickFacts
TennCare Bureau. PSA data is unweighted average or total of county data.
NR means not reported in U.S. Census source document.

C(I).4.B. DESCRIBE THE SPECIAL NEEDS OF THE SERVICE AREA POPULATION, INCLUDING HEALTH DISPARITIES, THE ACCESSIBILITY TO CONSUMERS, PARTICULARLY THE ELDERLY, WOMEN, RACIAL AND ETHNIC MINORITIES, AND LOW-INCOME GROUPS. DOCUMENT HOW THE BUSINESS PLANS OF THE FACILITY WILL TAKE INTO CONSIDERATION THE SPECIAL NEEDS OF THE SERVICE AREA POPULATION.

Like other services of Summit Medical Center, this proposed small medical-surgical bed expansion will be accessible to the above groups. It will accept both Medicare and TennCare patients.

C(I).5. DESCRIBE THE EXISTING OR CERTIFIED SERVICES, INCLUDING APPROVED BUT UNIMPLEMENTED CON'S, OF SIMILAR INSTITUTIONS IN THE SERVICE AREA. INCLUDE UTILIZATION AND/OR OCCUPANCY TRENDS FOR EACH OF THE MOST RECENT THREE YEARS OF DATA AVAILABLE FOR THIS TYPE OF PROJECT. BE CERTAIN TO LIST EACH INSTITUTION AND ITS UTILIZATION AND/OR OCCUPANCY INDIVIDUALLY. INPATIENT BED PROJECTS MUST INCLUDE THE FOLLOWING DATA: ADMISSIONS OR DISCHARGES, PATIENT DAYS, AND OCCUPANCY. OTHER PROJECTS SHOULD USE THE MOST APPROPRIATE MEASURES, E.G., CASES, PROCEDURES, VISITS, ADMISSIONS, ETC.

Table Nine on the following page shows all available Joint Annual Report data on acute care bed utilization for service area hospitals. The C2013 data are not yet available; so these data are almost two years behind the year of this application. The overall service area occupancy of the ten comparable licensed general hospital campuses in 2012 was 60%, and it has been increasing slowly over the years. For the years 2010-12, beds and overall average length of stay have remained constant--while admissions, patient days, and average occupancies have been steadily increasing.

However, these TDH statistics do not include observation days, which have become significant factors for most hospitals, in that those patients in fact occupy beds and their care is reimbursed on special schedules by insurors. If they were included in JAR statistics, hospitals' occupancies would be higher. As an example, see Summit's Table Ten in the next section of this application.

Table Nine: General Acute Care Hospital Utilization in Primary Service Area 2010-2012

2010 Joint Annual Reports of Hospitals

State ID	Facility Name	County	Licensed Beds	Admissions	Days	Avg Length of Stay (Days)	Avg Daily Census (Patients)	Occupancy on Licensed Beds
	Centennial Medical Center	Davidson	606	23,930	145,665	6	399	65.9%
	Metro NV General Hospital	Davidson	150	4,925	22,987	5	63	42.0%
	Saint Thomas Midtown Hospital	Davidson	683	24,438	115,299	5	316	46.3%
	Saint Thomas West Hospital	Davidson	541	22,806	102,851	5	282	52.1%
	Skyline Medical Center, Nashville	Davidson	213	8,950	48,437	5	133	62.3%
	Southern Hills Medical Center	Davidson	120	3,580	15,042	4	41	34.3%
	Summit Medical Center	Davidson	188	9,148	38,786	4	106	56.5%
	The Center for Spinal Surgery	Davidson	23	1,273	1,702	1	5	20.3%
	Vanderbilt Medical Center	Davidson	916	48,972	265,095	5	726	79.3%
	University Medical Center (UMC)	Wilson	170	5,904	27,512	5	75	44.3%
	SERVICE AREA TOTALS		**3,610**	**153,926**	**783,376**	**5**	**2,146**	**59.5%**

2011 Joint Annual Reports of Hospitals

State ID	Facility Name	County	Licensed Beds	Admissions	Days	Avg Length of Stay (Days)	Avg Daily Census (Patients)	Occupancy on Licensed Beds
	Centennial Medical Center	Davidson	606	23,187	139,114	6	381	62.9%
	Metro NV General Hospital	Davidson	150	4,570	21,027	5	58	38.4%
	Saint Thomas Midtown Hospital	Davidson	683	24,448	113,135	5	310	45.4%
	Saint Thomas West Hospital	Davidson	541	22,623	102,534	5	281	51.9%
	Skyline Medical Center, Nashville	Davidson	213	9,152	51,710	6	142	66.5%
	Southern Hills Medical Center	Davidson	120	3,548	15,693	4	43	35.8%
	Summit Medical Center	Davidson	188	9,984	39,877	4	109	58.1%
	The Center for Spinal Surgery	Davidson	23	1,127	1,505	1	4	17.9%
	Vanderbilt Medical Center	Davidson	916	49,174	275,500	6	755	82.4%
	University Medical Center (UMC)	Wilson	170	5,719	25,679	4	70	41.4%
	SERVICE AREA TOTALS		**3,610**	**153,532**	**785,774**	**5**	**2,153**	**59.6%**

2012 Joint Annual Reports of Hospitals

State ID	Facility Name	County	Licensed Beds	Admissions	Days	Avg Length of Stay (Days)	Avg Daily Census (Patients)	Occupancy on Licensed Beds
	Centennial Medical Center	Davidson	606	25,830	147,903	6	405	66.9%
	Metro NV General Hospital	Davidson	150	4,069	17,401	4	48	31.8%
	Saint Thomas Midtown Hospital	Davidson	683	24,189	112,163	5	307	45.0%
	Saint Thomas West Hospital	Davidson	541	22,621	100,202	4	275	50.7%
	Skyline Medical Center, Nashville	Davidson	213	9,773	52,021	5	143	66.9%
	Southern Hills Medical Center	Davidson	120	4,077	17,845	4	49	40.7%
	Summit Medical Center	Davidson	188	10,779	42,722	4	117	62.3%
	The Center for Spinal Surgery	Davidson	23	1,144	1,519	1	4	18.1%
	Vanderbilt Medical Center	Davidson	916	50,240	275,013	5	753	82.3%
	University Medical Center (UMC)	Wilson	170	5,528	24,279	4	67	39.1%
	SERVICE AREA TOTALS		**3,610**	**158,250**	**791,068**	**5**	**2,167**	**60.0%**

Note: Listed facilities exclude dedicated rehabilitation, long-term acute, and psychiatric facilities

C(I).6. PROVIDE APPLICABLE UTILIZATION AND/OR OCCUPANCY STATISTICS FOR YOUR INSTITUTION FOR EACH OF THE PAST THREE (3) YEARS AND THE PROJECTED ANNUAL UTILIZATION FOR EACH OF THE TWO (2) YEARS FOLLOWING COMPLETION OF THE PROJECT. ADDITIONALLY, PROVIDE THE DETAILS REGARDING THE METHODOLOGY USED TO PROJECT UTILIZATION. THE METHODOLOGY MUST INCLUDE DETAILED CALCULATIONS OR DOCUMENTATION FROM REFERRAL SOURCES, AND IDENTIFICATION OF ALL ASSUMPTIONS.

Summit Medical Center on Interstate 40 is the only hospital located in or near the populous and growing communities of eastern Davidson County and western Wilson County. Summit opened a major Emergency Department Expansion in July 2011, and received Accreditation as a Primary Stroke Care Center in November 2011. As a result of these and other service improvements, the hospital's medical-surgical bed resources are stretched very tightly.

Table Ten on the following page provides Summit's actual utilization by bed assignment, for the prior three years (CYP2011-13), and projected utilization by bed assignment for CY2014-2016. The methodologies for the projections are provided on a Notes page following the Table.

Note the significant difference in "occupancy" when considering observation patients along with fully admitted patients--a 9% to 10% increase in occupancy for medical-surgical beds. The JAR occupancy data in Table Nine above does not include observation patient days, although observation patients take up beds and are reimbursed by insurors. In CY2013, Summit's actual occupancy on its medical-surgical beds was 87.5%. But based only on admitted inpatients, those beds were less than 80% occupied.

Table Ten: Summit Medical Center
Utilization of Licensed Beds, CY 2010 - CY 2013
Projected Utilization of Licensed Beds, CY 2014-2016

	Actual 2011	Actual 2012	Actual 2013	Projected 2014	Project Year One Projected 2015	Project Year Two Projected 2016
Total Beds	188	188	188	188	196	196
Admissions	9,984	10,737	10,598	10,679	10,979	11,288
Patient Days	38,552	42,673	43,019	44,941	46,282	47,666
ALOS on Admissions	3.9	3.97	4.06	4.21	4.22	4.22
ADC on Admissions	105.6	116.6	117.9	123.1	126.8	130.6
Occupancy on Admissions	56.2%	62.0%	62.7%	65.5%	64.7%	66.6%
23-Hour Observation Days	4,676	4,183	4,383	4,504	4,628	4,797
Total Bed Days	46,367	46,825	47,402	49,445	50,910	52,463
Total ADC	127.0	128.3	129.9	135.5	139.5	143.7
Total Occupancy	67.6%	68.2%	69.1%	72.1%	71.2%	73.3%
Medical-Surgical Beds	110	110	110	118	126	126
Admissions	6,713	7,541	7,589	7,703	7,934	8,172
Patient Days	27,134	29,794	31,294	31,763	32,716	33,698
ALOS on Admissions	4.0	4.0	4.1	4.1	4.1	4.1
ADC on Admissions	74.3	81.6	85.7	87.0	89.6	92.3
Occupancy on Admissions	67.6%	74.2%	77.9%	73.7%	71.1%	73.3%
23-Hour Observation Days	4,427	3,673	3,849	3,964	4,083	4,246
Total Bed Days	31,561	33,467	35,143	35,727	36,799	37,944
Total ADC	86.5	91.7	96.3	97.9	100.8	104.0
Total Occupancy	78.6%	83.4%	87.5%	83.0%	80.0%	82.5%
Critical & Intermediate Care Beds	24	24	24	24	24	24
Admissions	1,163	1,284	1,344	1,384	1,426	1,469
Patient Days	5,601	4,804	5,024	5,175	5,330	5,490
ALOS on Admissions	4.8	3.7	3.7	3.7	3.7	3.7
ADC on Admissions	15.3	13.2	13.8	14.2	14.6	15.0
Occupancy on Admissions	63.9%	54.8%	57.4%	59.1%	60.8%	62.7%
23-Hour Observation Days	0	0	0	0	0	0
Total Bed Days	5,601	4,804	5,024	5,175	5,330	5,490
Total ADC	15.3	13.2	13.8	14.2	14.6	15.0
Total Occupancy	63.9%	54.8%	57.4%	59.1%	60.8%	62.7%
NICU Beds	10	10	10	10	10	10
Admissions	62	49	77	78	79	79
Patient Days	814	750	1,203	1,215	1,227	1,239
ALOS on Admissions	13.1	15.3	15.6	15.6	15.6	15.6
ADC on Admissions	2.2	2.1	3.3	3.3	3.4	3.4
Occupancy on Admissions	22.3%	20.5%	33.0%	33.3%	33.6%	34.0%
23-Hour Observation Days	0	0	0	0	0	0
Total Bed Days	814	750	1,203	1,215	1,227	1,239
Total ADC	2.2	2.1	3.3	3.3	3.4	3.4
Total Occupancy	22.3%	20.5%	33.0%	33.3%	33.6%	34.0%
Rehabilitation Beds	0	0	12	12	12	12
Admissions	0	0	1	270	284	299
Patient Days	0	0	4	3,645	3,834	4,033
ALOS on Admissions	0.0	0.0	0.0	13.5	13.5	13.5
ADC on Admissions	0.0	0.0	0.0	10.0	10.5	11.0
Occupancy on Admissions	0.0%	0.0%	0.0%	83.2%	87.5%	92.1%
23-Hour Observation Days	0	0	0	0	0	0
Total Bed Days	0	0	4	3,645	3,834	4,033
Total ADC	0.0	0.0	0.0	10.0	10.5	11.0
Total Occupancy	0.0%	0.0%	0.0%	83.2%	87.5%	92.1%
Obstetrical Beds	24	24	24	24	24	24
Admissions	1,232	1,184	1,232	1,244	1,257	1,269
Patient Days	3,139	3,000	3,112	3,143	3,175	3,206
ALOS on Admissions	2.5	2.5	2.5	2.5	2.5	2.5
ADC on Admissions	8.6	8.2	8.5	8.6	8.7	8.8
Occupancy on Admissions	35.8%	34.2%	35.5%	35.9%	36.2%	36.6%
23-Hour Observation Days	249	510	534	540	545	551
Total Bed Days	3,388	3,510	3,646	3,683	3,720	3,757
Total ADC	9.3	9.6	10.0	10.1	10.2	10.3
Total Occupancy	38.7%	40.1%	41.6%	42.0%	42.5%	42.9%
Pediatric Beds	0	0	0	0	0	0
Admissions	0	0	0	0	0	0
Patient Days	0	0	0	0	0	0
ALOS on Admissions	0.0	0.0	0.0	0.0	0.0	0.0
ADC on Admissions	0.0	0.0	0.0	0.0	0.0	0.0
Occupancy on Admissions	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
23-Hour Observation Days	0	0	0	0	0	0
Total Bed Days	0	0	0	0	0	0
Total ADC	0.0	0.0	0.0	0.0	0.0	0.0
Total Occupancy	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Psychiatric Beds	20	20	20	0	0	0
Admissions	814	647	355	0	0	0
Patient Days	5,003	4,294	2,382	0	0	0
ALOS on Admissions	6.1	6.6	6.7	#DIV/0!	0.0	0.0
ADC on Admissions	13.7	11.8	6.5	0.0	0.0	0.0
Occupancy on Admissions	68.5%	58.8%	32.6%	#DIV/0!	0.0%	0.0%
23-Hour Observation Days	0	0	0	0	0	0
Total Bed Days	5,003	4,294	2,382	0	0	0
Total ADC	13.7	11.8	6.5	0.0	0.0	0.0
Total Occupancy	68.5%	58.8%	32.6%	#DIV/0!	0.0%	0.0%

*The 20 Psych beds were closed in August 2013 and converted to 12 Inpatient Rehab beds (opened December 2013) and 8 Ortho total Joint beds (will open in March 2014)..

NOTES TO TABLE TEN

1. Medical-surgical admissions are projected to increase by 1.5% in 2014, and 3% annually for the next two years through 2016.

2. Critical Care Unit admissions are projected to increase at 3% annually for 2014-2016.

3. The rehabilitation unit admissions reflect projections from prior approved CN1304-011. These beds just opened at the end of CY2013.

4. Obstetrics admissions are projected to increase 1% annually in 2014-2015.

5. As a result of the above projections, TriStar Summit Medical Center's overall bed utilization *(admitted patients plus observation patients)* is expected to increase from 69.1% in 2013, to 73.3% in CY2016. Medical-surgical bed occupancy *(admitted plus observation patients)* is projected to change from 87.5% on 110 beds in 2013, to 83% on 118 beds in 2014, and to reach 82.5% on 126 beds in 2016. During this period, admissions will be increasing every year.

NOTE: This table presents both occupancy on admissions, and also occupancy on admissions + observation patients. In bed units, significant numbers of observation days must now be included in any analysis of bed utilization. No longer an occasional use of beds, observation cases in patient beds now abound, as insurors seek to pay lower costs per day for patient care.

C(II)1. PROVIDE THE COST OF THE PROJECT BY COMPLETING THE PROJECT COSTS CHART ON THE FOLLOWING PAGE. JUSTIFY THE COST OF THE PROJECT.

• ALL PROJECTS SHOULD HAVE A PROJECT COST OF AT LEAST $3,000 ON LINE F (MINIMUM CON FILING FEE). CON FILING FEE SHOULD BE CALCULATED ON LINE D.

• THE COST OF ANY LEASE (BUILDING, LAND, AND/OR EQUIPMENT) SHOULD BE BASED ON FAIR MARKET VALUE OR THE TOTAL AMOUNT OF THE LEASE PAYMENTS OVER THE INITIAL TERM OF THE LEASE, WHICHEVER IS GREATER. NOTE: THIS APPLIES TO ALL EQUIPMENT LEASES INCLUDING BY PROCEDURE OR "PER CLICK" ARRANGEMENTS. THE METHODOLOGY USED TO DETERMINE THE TOTAL LEASE COST FOR A "PER CLICK" ARRANGEMENT MUST INCLUDE, AT A MINIMUM, THE PROJECTED PROCEDURES, THE "PER CLICK" RATE AND THE TERM OF THE LEASE.

• THE COST FOR FIXED AND MOVEABLE EQUIPMENT INCLUDES, BUT IS NOT NECESSARILY LIMITED TO, MAINTENANCE AGREEMENTS COVERING THE EXPECTED USEFUL LIFE OF THE EQUIPMENT; FEDERAL, STATE, AND LOCAL TAXES AND OTHER GOVERNMENT ASSESSMENTS; AND INSTALLATION CHARGES, EXCLUDING CAPITAL EXPENDITURES FOR PHYSICAL PLANT RENOVATION OR IN-WALL SHIELDING, WHICH SHOULD BE INCLUDED UNDER CONSTRUCTION COSTS OR INCORPORATED IN A FACILITY LEASE.

• FOR PROJECTS THAT INCLUDE NEW CONSTRUCTION, MODIFICATION, AND/OR RENOVATION; DOCUMENTATION MUST BE PROVIDED FROM A CONTRACTOR AND/OR ARCHITECT THAT SUPPORT THE ESTIMATED CONSTRUCTION COSTS.

The architect's letter supporting the construction cost estimate is provided in Attachment C, Economic Feasibility--1. On the Project Costs Chart, following this response:

Line A.1, A&E fees, were estimated by the project architect.

Line A.2, legal, administrative, and consultant fees, include a contingency for additional expenses that may be incurred in the event of opposition before the Board.

Line A.5, construction cost, was calculated at approximately $156.78 PSF renovation cost for both components of the project. The estimate was made by HCA Corporate Design and Construction staff.

Line A.8 includes both fixed and moveable equipment costs, estimated by HCA Corporate Design and Construction staff. It includes information systems and telecommunications upgrades and replacements.

PROJECT COSTS CHART--SUMMIT MEDICAL CENTER / 8 MEDICAL-SURGICAL BEDS

A.	Construction and equipment acquired by purchase:	
1.	Architectural and Engineering Fees	$ 88,000
2.	Legal, Administrative, Consultant Fees (Excl CON Filing)	30,000
3.	Acquisition of Site	0
4.	Preparation of Site	0
5.	Construction Cost	1,161,133
6.	Contingency Fund	65,015
7.	Fixed Equipment (not in Construction Contract) in A8	0
8.	Moveable Equipment (List all equipment over $50,000)	464,185
9.	Other (Specify) _____	0
B.	Acquisition by gift, donation, or lease:	
1.	Facility (inclusive of building and land)	0
2.	Building only	0
3.	Land only	0
4.	Equipment (Specify) _____	0
5.	Other (Specify) _____	0
C.	Financing Costs and Fees:	
1.	Interim Financing	0
2.	Underwriting Costs	0
3.	Reserve for One Year's Debt Service	0
4.	Other (Specify) _____	0
D.	Estimated Project Cost (A+B+C)	1,808,333
E.	CON Filing Fee	4,069
F.	Total Estimated Project Cost (D+E)	TOTAL $ 1,812,402

Actual Capital Cost 1,812,402
Section B FMV 0

C(II).2. IDENTIFY THE FUNDING SOURCES FOR THIS PROJECT.

a. PLEASE CHECK THE APPLICABLE ITEM(S) BELOW AND BRIEFLY SUMMARIZE HOW THE PROJECT WILL BE FINANCED. (DOCUMENTATION FOR THE TYPE OF FUNDING MUST BE INSERTED AT THE END OF THE APPLICATION, IN THE CORRECT ALPHANUMERIC ORDER AND IDENTIFIED AS ATTACHMENT C, ECONOMIC FEASIBILITY--2).

_____A. Commercial Loan--Letter from lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions;

_____B. Tax-Exempt Bonds--copy of preliminary resolution or a letter from the issuing authority, stating favorable contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance;

_____C. General Obligation Bonds--Copy of resolution from issuing authority or minutes from the appropriate meeting;

_____D. Grants--Notification of Intent form for grant application or notice of grant award;

__x___E. Cash Reserves--Appropriate documentation from Chief Financial Officer; or

_____F. Other--Identify and document funding from all sources.

The project will be funded by a cash transfer from the applicant's parent company (HCA, Inc.) to the applicant's division office (TriStar Health System). Documentation of financing is provided in Attachment C, Economic Feasibility--2.

C(II).3. DISCUSS AND DOCUMENT THE REASONABLENESS OF THE PROPOSED PROJECT COSTS. IF APPLICABLE, COMPARE THE COST PER SQUARE FOOT OF CONSTRUCTION TO SIMILAR PROJECTS RECENTLY APPROVED BY THE HSDA.

The estimated $1,163,133 renovation cost of the project is approximately $157 per SF--with the bed wing averaging approximately $224 PSF, and the Sleep Lab MOB renovation averaging approximately $59 PSF (these are rounded numbers).

Table Two (Repeated): Construction Cost PSF			
Component	**Construction Cost**	**SF of Renovation**	**Construction Cost PSF**
7th Floor Beds	$984,973	4,406	$223.55
Sleep Lab	$176,160	3,000	$58.72
Total Project	*$1,161,133*	*7,406*	*$156.78*

The 2010-12 hospital construction projects approved by the HSDA had the following costs per SF. The Summit project's bed wing construction cost of approximately $224 PSF is below the 3rd quartile average Statewide. The project's overall total construction cost average of approximately $157 PSF is below the Statewide median.

Table Three (Repeated): Hospital Construction Cost Per Square Foot Applications Approved by the HSDA Years: 2010 – 2012			
	Renovation	**New Construction**	**Total Construction**
1st Quartile	$99.12/sq ft	$234.64/sq ft	$167.99/sq ft
Median	$177.60/sq ft	$259.66/sq ft	$235.00/sq ft
3rd Quartile	$249.00/sq ft	$307.80/sq ft	$274.63/sq ft

Source: Health Services and Development Agency website, 2014

C(II).4. COMPLETE HISTORICAL AND PROJECTED DATA CHARTS ON THE FOLLOWING TWO PAGES--DO NOT MODIFY THE CHARTS PROVIDED OR SUBMIT CHART SUBSTITUTIONS. HISTORICAL DATA CHART REPRESENTS REVENUE AND EXPENSE INFORMATION FOR THE LAST THREE (3) YEARS FOR WHICH COMPLETE DATA IS AVAILABLE FOR THE INSTITUTION. PROJECTED DATA CHART REQUESTS INFORMATION FOR THE TWO YEARS FOLLOWING COMPLETION OF THIS PROPOSAL. PROJECTED DATA CHART SHOULD INCLUDE REVENUE AND EXPENSE PROJECTIONS FOR THE PROPOSAL ONLY (I.E., IF THE APPLICATION IS FOR ADDITIONAL BEDS, INCLUDE ANTICIPATED REVENUE FROM THE PROPOSED BEDS ONLY, NOT FROM ALL BEDS IN THE FACILITY).

See the following pages for these charts, with notes where applicable.

For both the historic and projected charts, there is a "management fee" indicated to an affiliated company (HCA, the parent company). That does not indicate an actual management contract. It is the way HCA allocates its corporate expenses to all the hospitals comprising the company. On the projected data chart that is estimated to be 6.6% of net operating revenues, the amount charged to the hospital in CY2013. The percent varies from year to year; the past three years it has been within the range of 5.8% to 6.9% of net operating revenue.

In the Projected Data Chart's "Other" expenses, there is an item named Parallon. It is a recently organized, wholly owned subsidiary of HCA. It provides support services for the hospitals and allocates the costs of those services back to the hospitals. The services provided by Parallon include:

--All normal Business Office functions (billing, collections, cashiering, etc.)
--Central Scheduling
--Revenue Integrity (chart auditing, charge capture, charge master maintenance)
--Credentialing Functions
--Supply Chain--Materials Management, Accounts Payable & Warehouse
--Payroll functions
--Health Information Management (Medical Records) functions

HISTORICAL DATA CHART -- SUMMIT MEDICAL CENTER

Give information for the last three (3) years for which complete data are available for the facility or agency.
The fiscal year begins in January.

		Year 2011	Year 2012	Year 2013
A.	Utilization Data (JAR discharge days)	39,877	42,673	43,019
B.	Revenue from Services to Patients			
1.	Inpatient Services	$ 371,674,202	419,876,431	471,166,152
2.	Outpatient Services	236,798,113	277,624,464	313,817,163
3.	Emergency Services	46,936,541	58,231,463	69,312,426
4.	Other Operating Revenue	2,369,656	3,098,445	2,291,519
	(Specify) See notes			
	Gross Operating Revenue	$ 657,778,512	$ 758,830,803	$ 856,587,260
C.	Deductions for Operating Revenue			
1.	Contractual Adjustments	$ 456,728,007	525,148,823	615,134,716
2.	Provision for Charity Care	3,723,069	5,390,825	5,797,935
3.	Provisions for Bad Debt	44,276,197	60,246,469	58,793,735
	Total Deductions	$ 504,727,273	$ 590,786,117	$ 679,726,386
NET OPERATING REVENUE		$ 153,051,239	$ 168,044,686	$ 176,860,874
D.	Operating Expenses			
1.	Salaries and Wages	$ 42,613,777	44,289,349	45,542,436
2.	Physicians Salaries and Wages	0	0	0
3.	Supplies	29,427,000	24,856,680	27,424,548
4.	Taxes	1,202,224	1,339,041	1,304,871
5.	Depreciation	7,017,441	7,489,453	7,010,478
6.	Rent	1,911,000	1,711,583	1,909,577
7.	Interest, other than Capital	243,557	249,857	252,138
8.	Management Fees			
	a. Fees to Affiliates	10,588,601	9,701,320	11,618,245
	b. Fees to Non-Affiliates	0	0	0
9.	Other Expenses (Specify) See notes	47,633,531	60,000,150	62,128,034
	Total Operating Expenses	$ 140,637,131	149,637,433	157,190,327
E.	Other Revenue (Expenses) -- Net (Specify)	$	$	$
NET OPERATING INCOME (LOSS)		$ 12,414,108	$ 18,407,253	$ 19,670,547
F.	Capital Expenditures			
1.	Retirement of Principal	$ 0	$ 0	$ 0
2.	Interest	0	0	0
	Total Capital Expenditures	$ 0	$ 0	$ 0
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES		$ 12,414,108	$ 18,407,253	$ 19,670,547

Notes for Other Operating Revenue, B.4	Year 2011	Year 2012	Year 2013
Fitness Center Dues	6,175	6,080	5,430
Cafeteria Sales	599,859	611,000	666,001
Cafeteria Catering Sales	2,855	6,630	0
Vending Machine Income	3,474	3,915	3,887
Other Income - Recycling	1,645	1,670	0
Xray Film Copies	600	886	755
Rental/Lease Income	67,881	69,478	74,695
Lease Income - Pediatrix	1,416	1,794	1,176
Lease Income - Dube MRI Block Lease	153,543	148,655	133,008
Lactation Pump Rental	41,858	36,996	29,438
Donations & Gifts - HRSA	14,862	12,358	24,169
Other Rental Income	(2)	0	0
Phys Therapy Cancel Fee TES			36
Voluntary Paternity Program	5,540	5,620	4,070
T-Mobile Tower Space Lease	20,807	21,432	24,829
NSQIP Grant	0	60,000	60,000
Child Birth Education	12,700	12,060	11,165
Plant Operations Labor Allocation - Holladay	(5,744)	(6,121)	(9,007)
Plant Operations Labor Allocation - ASC	18,255	15,953	12,560
Plant Operations Labor Allocation - Lebanon/MJ	2,330	2,494	1,735
Pharmacy Student Orientation Income	17,400	0	20,400
Lab Surveillance Honorarium	900	1,800	1,800
Medical Staff Dues	19,390	19,300	19,700
Other Income - Education	430	523	35
Lease Income - MOB Suite 455/555	102,253	108,011	89,472
Subtotal Other Revenue	1,088,427	1,140,534	1,175,354
Essential Access/DSH Pymt	755,420	887,998	798,420
Amerigroup Settlement	0	72,911	0
Medicare PY Contractual	248,663	858,838	252,233
Champus PY Contractual	138,977	138,164	65,512
TNCare FMAP Pool Distribution	138,169	0	
Subtotal PY Contractuals	1,281,229	1,957,911	1,116,165
Total Other Operating Revenue	**2,369,656**	**3,098,445**	**2,291,519**

Notes for Other Operating Expenses, D.9	Year 2011	Year 2012	Year 2013
Employee Benefits	12,925,000	12,541,770	12,437,834
Pro Fees	2,400,000	3,777,745	3,921,344
Ancillary Clinical Services	18,117,531	27,812,782	30,509,488
Contract Services (all)	14,191,000	15,867,853	15,259,368
Total	47,633,531	60,000,150	62,128,034
Management Fee	10,588,601	9,701,320	11,618,245
Net Operating Revenue	153,051,239	168,044,686	176,860,874
	6.9%	5.8%	6.6%

PROJECTED DATA CHART -- SUMMIT MEDICAL CENTER 8 BED MED-SURG EXPANSION

Give information for the two (2) years following the completion of this proposal.

The fiscal year begins in January.

			Year 2015	Year 2016
		Admissions	140	190
A.	Utilization Data	Patient Days	476	646
B.	Revenue from Services to Patients			
	1. Inpatient Services		$ 6,104,000	8,559,000
	2. Outpatient Services			
	3. Emergency Services			
	4. Other Operating Revenue (Specify)			
		Gross Operating Revenue	$ 6,104,000	$ 8,559,000
C.	Deductions for Operating Revenue			
	1. Contractual Adjustments		$ 4,378,000	$ 6,151,000
	2. Provision for Charity Care		183,000	256,000
	3. Provisions for Bad Debt		364,000	511,000
		Total Deductions	$ 4,925,000	$ 6,918,000
NET OPERATING REVENUE			$ 1,179,000	$ 1,641,000
D.	Operating Expenses			
	1. Salaries and Wages		$ 330,000	$ 460,000
	2. Physicians Salaries and Wages		-	-
	3. Supplies		179,000	253,000
	4. Taxes		-	-
	5. Depreciation		198,000	198,000
	6. Rent		56,000	57,000
	7. Interest, other than Capital		-	-
	8. Management Fees			
	a. Fees to Affiliates		77,814	108,306
	b. Fees to Non-Affiliates			
	9. Other Expenses (Specify)	See notes	223,000	316,000
		Total Operating Expenses	$ 1,063,814	$ 1,392,306
E.	Other Revenue (Expenses) -- Net (Specify)		$	$
NET OPERATING INCOME (LOSS)			$ 115,186	$ 248,694
F.	Capital Expenditures			
	1. Retirement of Principal		$	$
	2. Interest			
		Total Capital Expenditures	$ -	$ -
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES			$ 115,186	$ 248,694

Notes to Projected Data Chart -- 8 bed Wing D.9: Other expenses:	Year 2015	Year 2016
Employee Benefits	89,000	126,000
Pro Fees	7,000	9,000
Repairs and Maintenance	27,000	41,000
Ancillary Clinical Services	55,732	79,922
Parallon Allocations	44,268	60,078
	223,000	316,000
Management Fee (6.6 % of NR - 2013 rate)	77,814	108,306

C(II).5. PLEASE IDENTIFY THE PROJECT'S AVERAGE GROSS CHARGE, AVERAGE DEDUCTION FROM OPERATING REVENUE, AND AVERAGE NET CHARGE.

Table Eleven: Charges, Deductions, Net Charges, Net Operating Income		
	CY2016	**CY2017**
Admissions	140	190
Patient Days	476	646
Average Gross Charge Per Day	$12,824	$13,249
Average Gross Charge Per Admission	$43,600	$45,047
Average Deduction from Operating Revenue Per Day	$10,347	$10,709
Average Deduction from Operating Revenue Per Admiss.	$35,179	$36,411
Average Net Charge (Net Operating Revenue) Per Day	$2,477	$2,540
Average Net Charge (Net Operating Revenue) Per Admiss.	$8,421	$8,637
Average Net Operating Income after Expenses, Per Day	$242	$385
Average Net Operating Income after Expenses, Per Admiss.	$823	$1,309

Source: Projected Data Chart, by hospital management.

C(II).6.A. PLEASE PROVIDE THE CURRENT AND PROPOSED CHARGE SCHEDULES FOR THE PROPOSAL. DISCUSS ANY ADJUSTMENT TO CURRENT CHARGES THAT WILL RESULT FROM THE IMPLEMENTATION OF THE PROPOSAL. ADDITIONALLY, DESCRIBE THE ANTICIPATED REVENUE FROM THE PROPOSED PROJECT AND THE IMPACT ON EXISTING PATIENT CHARGES.

The project's most frequent charges for medical-surgical admissions are shown in response to C(II).6.B below. The addition of the proposed eight beds will not affect any hospital charges. Medical-surgical admissions tend to operate with a positive revenue margin, making it unnecessary to shift costs to other hospital services. This eight-bed addition is projected to have a positive revenue margin.

C(II).6.B. COMPARE THE PROPOSED CHARGES TO THOSE OF SIMILAR FACILITIES IN THE SERVICE AREA/ADJOINING SERVICE AREAS, OR TO PROPOSED CHARGES OF PROJECTS RECENTLY APPROVED BY THE HSDA. IF APPLICABLE, COMPARE THE PROJECTED CHARGES OF THE PROJECT TO THE CURRENT MEDICARE ALLOWABLE FEE SCHEDULE BY COMMON PROCEDURE TERMINOLOGY (CPT) CODE(S).

There is no publicly available data by which medical and/or surgical patient charges can be compared to those of the other hospitals in the service area. Table Twelve on the following page compares the service area hospitals' total gross charges (revenues) per admission and per day.

Table Thirteen on the second following page shows the most frequent DRG's of Summit's medical-surgical admissions, with their current Medicare reimbursement, and their projected Years One and Two utilization and average gross charges.

Table Twelve: Comparative Gross Charges for General Acute Care Hospitals in the Primary Service Area 2012							
	2012 Joint Annual Reports of Hospitals						
State ID	Facility Name	County	Total Gross Revenues	Admissions	Days	Gross Revenues Per Admission	Gross Revenues Per Day
	The Center for Spinal Surgery	Davidson	$120,064,474	1,144	1,519	$104,951.46	$79,041.79
	University Medical Center (UMC)	Wilson	$615,719,170	5,528	24,279	$111,381.90	$25,360.15
	Southern Hills Medical Center	Davidson	$404,916,361	4,077	17,845	$99,317.23	$22,690.75
	Vanderbilt Medical Center	Davidson	$5,453,993,390	50,240	275,013	$108,558.79	$19,831.77
	Skyline Medical Center, Nashville	Davidson	$928,727,278	9,773	52,021	$95,029.91	$17,852.93
	Summit Medical Center	***Davidson***	***$755,732,354***	***10,779***	***42,722***	***$70,111.55***	***$17,689.54***
	Centennial Medical Center	Davidson	$2,181,217,313	25,830	147,903	$84,445.11	$14,747.62
	Saint Thomas West Hospital	Davidson	$1,405,480,380	22,621	100,202	$62,131.66	$14,026.47
	Metro NV General Hospital	Davidson	$226,172,521	4,069	17,401	$55,584.30	$12,997.67
	Saint Thomas Midtown Hospital	Davidson	$1,260,376,438	24,189	112,163	$52,105.36	$11,237.01
	Skyline Medical Center, Madison	Davidson	$104,048,767	3,646	26,727	$28,537.79	$3,893.02
	SERVICE AREA TOTALS		**$13,456,448,446**	**161,896**	**817,795**	**$83,117.86**	**$16,454.55**

Table Thirteen: Summit Medical Center Most Frequent Admimssions Diagnoses and Average Gross Charges Current and Proposed					
DRG Code	DRG Description	Current Medicare Allowable	Average Gross Charge	Yr 1 Average Gross Charge	Yr 2 Average Gross Charge
190	Ch obst pulm dis w MCC	$6,667	$37,858	$39,183	$40,554
191	Ch obst pulm dis w CC	$5,320	$31,711	$32,821	$33,969
194	Simp pneu/pleu w CC	$5,564	$32,119	$33,243	$34,406
291	Heart fail/shock w MCC	$8,559	$46,522	$48,151	$49,836
292	Heart fail/shock w CC	$5,659	$27,996	$28,976	$29,990
392	Esoph, GE dig dis wo MCC	$4,211	$23,729	$24,560	$25,419
470	Maj join rep/reat LE w/o M	$11,741	$66,620	$68,952	$71,365
603	Cellulitis w/o MCC	$4,784	$22,900	$23,701	$24,531
690	Kidney/UTI wo MCC	$4,380	$25,167	$26,048	$26,960
871	SEPTI/SEPS WO MV96+HR WMCC	$10,549	$63,211	$65,424	$67,713

Source: Hospital Management

C(II).7. DISCUSS HOW PROJECTED UTILIZATION RATES WILL BE SUFFICIENT TO MAINTAIN COST-EFFECTIVENESS.

The Projected Data Chart and charge information in the application demonstrate that the medical-surgical beds of this hospital will be cost-effective, and will operate with a positive financial margin.

C(II).8. DISCUSS HOW FINANCIAL VIABILITY WILL BE ENSURED WITHIN TWO YEARS; AND DEMONSTRATE THE AVAILABILITY OF SUFFICIENT CASH FLOW UNTIL FINANCIAL VIABILITY IS MAINTAINED.

The proposed expanded medical-surgical beds will be sufficiently utilized in their first two years to operate with a positive financial margin. Cash flow is positive and will remain so.

C(II).9. DISCUSS THE PROJECT'S PARTICIPATION IN STATE AND FEDERAL REVENUE PROGRAMS, INCLUDING A DESCRIPTION OF THE EXTENT TO WHICH MEDICARE, TENNCARE/MEDICAID, AND MEDICALLY INDIGENT PATIENTS WILL BE SERVED BY THE PROJECT. IN ADDITION, REPORT THE ESTIMATED DOLLAR AMOUNT OF REVENUE AND PERCENTAGE OF TOTAL PROJECT REVENUE ANTICIPATED FROM EACH OF TENNCARE, MEDICARE, OR OTHER STATE AND FEDERAL SOURCES FOR THE PROPOSAL'S FIRST YEAR OF OPERATION.

Summit Medical Center's medical-surgical beds serve all of the groups listed above. Summit projects charity at approximately 1% of gross revenues; and Medicare and TennCare/Medicaid are projected at a combined 56.6% of services.

Table Fourteen: Medicare and TennCare/Medicaid Gross Revenues, Year One		
	Medicare	**TennCare/Medicaid**
Gross Revenue	$2,789,528	$665,336
Percent of Gross Revenue	45.7%	10.9%

Source: Hospital management

C(II).10. PROVIDE COPIES OF THE BALANCE SHEET AND INCOME STATEMENT FROM THE MOST RECENT REPORTING PERIOD OF THE INSTITUTION, AND THE MOST RECENT AUDITED FINANCIAL STATEMENTS WITH ACCOMPANYING NOTES, IF APPLICABLE. FOR NEW PROJECTS, PROVIDE FINANCIAL INFORMATION FOR THE CORPORATION, PARTNERSHIP, OR PRINCIPAL PARTIES INVOLVED WITH THE PROJECT. COPIES MUST BE INSERTED AT THE END OF THE APPLICATION, IN THE CORRECT ALPHANUMERIC ORDER AND LABELED AS ATTACHMENT C, ECONOMIC FEASIBILITY--10.

These are provided as Attachment C, Economic Feasibility--10.

C(II)11. DESCRIBE ALL ALTERNATIVES TO THIS PROJECT WHICH WERE CONSIDERED AND DISCUSS THE ADVANTAGES AND DISADVANTAGES OF EACH ALTERNATIVE, INCLUDING BUT NOT LIMITED TO:
A. A DISCUSSSION REGARDING THE AVAILABILITY OF LESS COSTLY, MORE EFFECTIVE, AND/OR MORE EFFICIENT ALTERNATIVE METHODS OF PROVIDING THE BENEFITS INTENDED BY THE PROPOSAL. IF DEVELOPMENT OF SUCH ALTERNATIVES IS NOT PRACTICABLE, THE APPLICANT SHOULD JUSTIFY WHY NOT, INCLUDING REASONS AS TO WHY THEY WERE REJECTED.
B. THE APPLICANT SHOULD DOCUMENT THAT CONSIDERATION HAS BEEN GIVEN TO ALTERNATIVES TO NEW CONSTRUCTION, E.G., MODERNIZATION OR SHARING ARRANGEMENTS. IT SHOULD BE DOCUMENTED THAT SUPERIOR ALTERNATIVES HAVE BEEN IMPLEMENTED TO THE MAXIMUM EXTENT PRACTICABLE.

With respect to construction, the project requires no new construction. It will be done entirely by renovation. With respect to alternatives, there is no alternative way to make acute care beds more accessible to residents of the suburban eastern edge of Davidson County and adjoining western Wilson County. Summit is the closest hospital to these communities, who use it intensively.

The annual average occupancy of the hospital's 110 medical-surgical beds, including observation patients using licensed beds, reached 87.5% in CY2013 and continuing increases in admissions are expected. As discussed in prior sections of the application, midweek occupancies were even higher. This eight-bed expansion is the fastest and most economical way to relieve occupancy pressures.

C(III).1. LIST ALL EXISTING HEALTH CARE PROVIDERS (I.E., HOSPITALS, NURSING HOMES, HOME CARE ORGANIZATIONS, ETC.) MANAGED CARE ORGANIZATIONS, ALLIANCES, AND/OR NETWORKS WITH WHICH THE APPLICANT CURRENTLY HAS OR PLANS TO HAVE CONTRACTUAL AGREEMENTS FOR HEALTH SERVICES.

Following are the facilities most frequently utilizes in its discharge planning:

Skilled Nursing- McKendree, Mt. Juliet Healthcare, Donelson Place, Lebanon Health and Rehabilitation

Hospice- Alive Hospice, Odyssey, Avalon, Asera Care

Home Health- Suncrest, Gentevia, and Amedysis Home Health Care of Middle

Home Infusion- Walgreens, IV Solutions, Coram

DME- Medical Necessities, At Home Medical, Apria, All-Star

Summit Medical Center is fully contracted with all available TennCare MCO's in the Middle Tennessee Region. They are as follows:

Table One (Repeated): Contractual Relationships with Service Area MCO's	
Available TennCare MCO's	**Applicant's Relationship**
AmeriGroup	contracted
United Healthcare Community Plan (formerly AmeriChoice)	contracted
TennCare Select	contracted

C(III).2. DESCRIBE THE POSITIVE AND/OR NEGATIVE EFFECTS OF THE PROPOSAL ON THE HEALTH CARE SYSTEM. PLEASE BE SURE TO DISCUSS ANY INSTANCES OF DUPLICATION OR COMPETITION ARISING FROM YOUR PROPOSAL, INCLUDING A DESCRIPTION OF THE EFFECT THE PROPOSAL WILL HAVE ON THE UTILIZATION RATES OF EXISTING PROVIDERS IN THE SERVICE AREA OF THE PROJECT.

The project will improve local patients' accessibility to medical-surgical beds in the near term. Summit Medical Center in Hermitage is the only hospital in eastern Davidson County, between the central Davidson County hospitals (Centennial, Baptist, Saint Thomas Midtown) and University Medical Center in Lebanon. It was originally approved as this area's own community hospital--its only medical-surgical acute care resource close at hand. A very large medical community has grown up around Summit. When its medical-surgical beds are full, this delays the admission of local patients needing care, or forces them to change their providers--which may include their physicians--in order to obtain timely care. So the effects of this small expansion will be only beneficial. It is difficult to believe that licensure of eight additional beds at this location could have any significant negative impact on any other hospitals.

C(III).3. PROVIDE THE CURRENT AND/OR ANTICIPATED STAFFING PATTERN FOR ALL EMPLOYEES PROVIDING PATIENT CARE FOR THE PROJECT. THIS CAN BE REPORTED USING FTE'S FOR THESE POSITIONS. IN ADDITION, PLEASE COMPARE THE CLINICAL STAFF SALARIES IN THE PROPOSAL TO PREVAILING WAGE PATTERNS IN THE SERVICE AREA AS PUBLISHED BY THE TENNESSEE DEPARTMENT OF LABOR & WORKFORCE DEVELOPMENT AND/OR OTHER DOCUMENTED SOURCES.

Please see the following page for Table Sixteen, showing projected FTE's and salary ranges for both units.

The Department of Labor and Workforce Development website indicates the following Nashville area's hourly salary information for the clinical positions in this project:

Table Fifteen: TDOL Surveyed Average Salaries for the Region				
Position	**Entry Level**	**Median**	**Mean**	**Experienced**
RN	$21.55	$28.90	$31.00	$35.70

Table Sixteen: Summit Medical Center Eight-Bed Medical Wing, 7th Floor Staffing Requirements				
Position Type (RN, etc.)	**Med-Surg Department FTE's**	**Project Year One FTE's**	**Project Year Two FTE's**	**Salary Range (Hourly)**
WEST WING 8-BED UNIT				
RN	113.6	5.50	6.50	22.00 - 32.49
Certified Nurse Technician	48.9	1.50	2.00	15.40 - 17.00
Total FTE's, Seventh Floor Project	162.5	7.00	8.50	

Source: Hospital Management

Note: Department FTE's are for the entire Med-Surg Department; Project FTE's are for the proposed 8-bed addition.

C(III).4. DISCUSS THE AVAILABILITY OF AND ACCESSIBILITY TO HUMAN RESOURCES REQUIRED BY THE PROPOSAL, INCLUDING ADEQUATE PROFESSIONAL STAFF, AS PER THE DEPARTMENT OF HEALTH, THE DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES, AND/OR THE DIVISION OF MENTAL RETARDATION SERVICES LICENSING REQUIREMENTS.

TriStar anticipates no difficulties in attracting the very small increment of nursing staff needed to serve patients in these additional medical-surgical beds.

C(III).5. VERIFY THAT THE APPLICANT HAS REVIEWED AND UNDERSTANDS THE LICENSING CERTIFICATION AS REQUIRED BY THE STATE OF TENNESSEE FOR MEDICAL/CLINICAL STAFF. THESE INCLUDE, WITHOUT LIMITATION, REGULATIONS CONCERNING PHYSICIAN SUPERVISION, CREDENTIALING, ADMISSIONS PRIVILEGES, QUALITY ASSURANCE POLICIES AND PROGRAMS, UTILIZATION REVIEW PPOLICIES AND PROGRAMS, RECORD KEEPING, AND STAFF EDUCATION.

The applicant so verifies.

C(III).6. DISCUSS YOUR HEALTH CARE INSTITUTION'S PARTICIPATION IN THE TRAINING OF STUDENTS IN THE AREAS OF MEDICINE, NURSING, SOCIAL WORK, ETC. (I.E., INTERNSHIPS, RESIDENCIES, ETC.).

TriStar Summit Medical Center is a clinical rotation site for numerous students in the health professions. The colleges/universities with which Summit has student affiliation agreements include:

- Austin Peay State University
- Belmont
- Bethel
- Breckinridge
- Columbia State Community College
- Cumberland University
- East Tennessee State University
- Fortis Institute
- Lipscomb University
- Miller-Motte
- Middle Tennessee School of Anesthesia
- Middle Tennessee State University
- Southeastern Institute
- Tennessee State University
- Tennessee Tech Center @ Murfreesboro
- Trevecca University
- Union University
- Vanderbilt University
- Volunteer State Community College

In CY2013, Summit Medical Center served as a training rotation site for 381 students from these schools, in the following disciplines and programs: Nursing (149); EMT/Paramedic (79); CRNA's (64); Pharmacy (13); Nutrition (6); Respiratory Therapy (33); Medical Imaging (15); Physician's Assistant (8); Physical Therapy (3); Surgery (3); and Radiation Oncology (8).

C(III).7(a). PLEASE VERIFY, AS APPLICABLE, THAT THE APPLICANT HAS REVIEWED AND UNDERSTANDS THE LICENSURE REQUIREMENTS OF THE DEPARTMENT OF HEALTH, THE DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES, THE DIVISION OF MENTAL RETARDATION SERVICES, AND/OR ANY APPLICABLE MEDICARE REQUIREMENTS.

The applicant so verifies.

C(III).7(b). PROVIDE THE NAME OF THE ENTITY FROM WHICH THE APPLICANT HAS RECEIVED OR WILL RECEIVE LICENSURE, CERTIFICATION, AND/OR ACCREDITATION

LICENSURE: Board for Licensing of Health Care Facilities
Tennessee Department of Health

CERTIFICATION: Medicare Certification from CMS
TennCare Certification from TDH

ACCREDITATION: Joint Commission
1. Hospital (current)
2. Certified Primary Stroke Center

C(III).7(c). IF AN EXISTING INSTITUTION, PLEASE DESCRIBE THE CURRENT STANDING WITH ANY LICENSING, CERTIFYING, OR ACCREDITING AGENCY OR AGENCY.

The applicant is currently licensed in good standing by the Board for Licensing Health Care Facilities, certified for participation in Medicare and Medicaid/TennCare, and fully accredited by the Joint Commission.

C(III).7(d). FOR EXISTING LICENSED PROVIDERS, DOCUMENT THAT ALL DEFICIENCIES (IF ANY) CITED IN THE LAST LICENSURE CERTIFICATION AND INSPECTION HAVE BEEN ADDRESSED THROUGH AN APPROVED PLAN OF CORRECTION. PLEASE INCLUDE A COPY OF THE MOST RECENT LICENSURE/CERTIFICATION INSPECTION WITH AN APPROVED PLAN OF CORRECTION.

They have been addressed. A copy of the most recent licensure inspection and plan of correction, and/or the most recent accreditation inspection, are provided in Attachment C, Orderly Development--7(C). Summit Medical Center is also a Joint Commission-certified Primary Stroke Center.

C(III)8. DOCUMENT AND EXPLAIN ANY FINAL ORDERS OR JUDGMENTS ENTERED IN ANY STATE OR COUNTRY BY A LICENSING AGENCY OR COURT AGAINST PROFESSIONAL LICENSES HELD BY THE APPLICANT OR ANY ENTITIES OR PERSONS WITH MORE THAN A 5% OWNERSHIP INTEREST IN THE APPLICANT. SUCH INFORMATION IS TO BE PROVIDED FOR LICENSES REGARDLESS OF WHETHER SUCH LICENSE IS CURRENTLY HELD.

None.

C(III)9. IDENTIFY AND EXPLAIN ANY FINAL CIVIL OR CRIMINAL JUDGMENTS FOR FRAUD OR THEFT AGAINST ANY PERSON OR ENTITY WITH MORE THAN A 5% OWNERSHIP INTEREST IN THE PROJECT.

None.

C(III)10. IF THE PROPOSAL IS APPROVED, PLEASE DISCUSS WHETHER THE APPLICANT WILL PROVIDE THE THSDA AND/OR THE REVIEWING AGENCY INFORMATION CONCERNING THE NUMBER OF PATIENTS TREATED, THE NUMBER AND TYPE OF PROCEDURES PERFORMED, AND OTHER DATA AS REQUIRED.

Yes. The applicant will provide the requested data consistent with Federal HIPAA requirements.

PROOF OF PUBLICATION

Attached.

DEVELOPMENT SCHEDULE

1. PLEASE COMPLETE THE PROJECT COMPLETION FORECAST CHART ON THE NEXT PAGE. IF THE PROJECT WILL BE COMPLETED IN MULTIPLE PHASES, PLEASE IDENTIFY THE ANTICIPATED COMPLETION DATE FOR EACH PHASE.

The Project Completion Forecast Chart is provided after this page.

2. IF THE RESPONSE TO THE PRECEDING QUESTION INDICATES THAT THE APPLICANT DOES NOT ANTICIPATE COMPLETING THE PROJECT WITHIN THE PERIOD OF VALIDITY AS DEFINED IN THE PRECEDING PARAGRAPH, PLEASE STATE BELOW ANY REQUEST FOR AN EXTENDED SCHEDULE AND DOCUMENT THE "GOOD CAUSE" FOR SUCH AN EXTENSION.

Not applicable. The applicant anticipates completing the project within the period of validity.

PROJECT COMPLETION FORECAST CHART

Enter the Agency projected Initial Decision Date, as published in Rule 68-11-1609(c):

May 28, 2014

Assuming the CON decision becomes the final Agency action on that date, indicate the number of days from the above agency decision date to each phase of the completion forecast.

PHASE	DAYS REQUIRED	Anticipated Date (MONTH /YEAR)
1. Architectural & engineering contract signed	2	6-1-13
2. Construction documents approved by TDH	32	7-1-13
3. Construction contract signed	36	7-5-13
4. Building permit secured	51	7-20-13
5. Site preparation completed	na	na
6. Building construction commenced	61	8-1-14
7. Construction 40% complete	91	9-1-14
8. Construction 80% complete	121	10-1-14
9. Construction 100% complete	181	12-1-14
10. * Issuance of license (occupancy approval)	195	12-15-14
11. *Initiation of service	211	12-31-14
12. Final architectural certification of payment	271	3-1-14
13. Final Project Report Form (HF0055)	291	4-1-15

*** For projects that do NOT involve construction or renovation: please complete items 10-11 only.**

Note: If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date.

INDEX OF ATTACHMENTS

INDEX OF ATTACHMENTS

A.4	Ownership--Legal Entity and Organization Chart (if applicable)
A.6	Site Control
B.III.	Plot Plan
B.IV.	Floor Plan
C, Need--3	Service Area Maps
C, Economic Feasibility--1	Documentation of Construction Cost Estimate
C, Economic Feasibility--2	Documentation of Availability of Funding
C, Economic Feasibility--10	Financial Statements
C, Orderly Development--7(C)	TDH Inspection & Plan of Correction
Miscellaneous Information	
Support Letters	

A.4--Ownership
Legal Entity and Organization Chart

Board for Licensing Health Care Facilities

State of Tennessee

0000000033

No. of Beds 0188

DEPARTMENT OF HEALTH

This is to certify, that a license is hereby granted by the State Department of Health to

HCA HEALTH SERVICES OF TENNESSEE, INC. *to conduct and maintain a*

Hospital TRISTAR SUMMIT MEDICAL CENTER

Located at 5655 FRIST BOULEVARD, HERMITAGE

County of DAVIDSON *, Tennessee.*

85

This license shall expire APRIL 20 , 2014 , *and is subject to the provisions of Chapter 11, Tennessee Code Annotated. This license shall not be assignable or transferable, and shall be subject to revocation at any time by the State Department of Health, for failure to comply with the laws of the State of Tennessee or the rules and regulations of the State Department of Health issued thereunder.*

In Witness Whereof, we have hereunto set our hand and seal of the State this 20TH *day of* APRIL , 2013 .

In the Distinct Category(ies) of: GENERAL HOSPITAL
PEDIATRIC BASIC HOSPITAL

FEB 14 '14 AM 9:3

By Vincent J. Davis, MPH
DIRECTOR, DIVISION OF HEALTH CARE FACILITIES

By John J. Dreyzehner MD
COMMISSIONER

Summit Medical Center

Hermitage, TN

has been Accredited by

The Joint Commission

Which has surveyed this organization and found it to meet the requirements for the

Hospital Accreditation Program

May 26, 2012

Accreditation is customarily valid for up to 36 months.

Isabel V. Hoverman, MD, MACP
Chair, Board of Commissioners

Organization ID #: 7806
Print/Reprint Date: 08/21/12

Mark R. Chassin, MD, FACP, MPP, MPH
President

The Joint Commission is an independent, not-for-profit, national body that oversees the safety and quality of health care and other services provided in accredited organizations. Information about accredited organizations may be provided directly to The Joint Commission at 1-800-994-6610. Information regarding accreditation and the accreditation performance of individual organizations can be obtained through The Joint Commission's web site at www.jointcommission.org.

CERTIFICATE OF DISTINCTION

has been awarded to

TriStar Summit Medical Center

Hermitage, TN

for Advanced Certification as a

Primary Stroke Center

by

THE JOINT COMMISSION
NATIONAL QUALITY APPROVAL

The Joint Commission

based on a review of compliance with national standards, clinical guidelines and outcomes of care

August 9, 2013

Certification is customarily valid for up to 24 months.

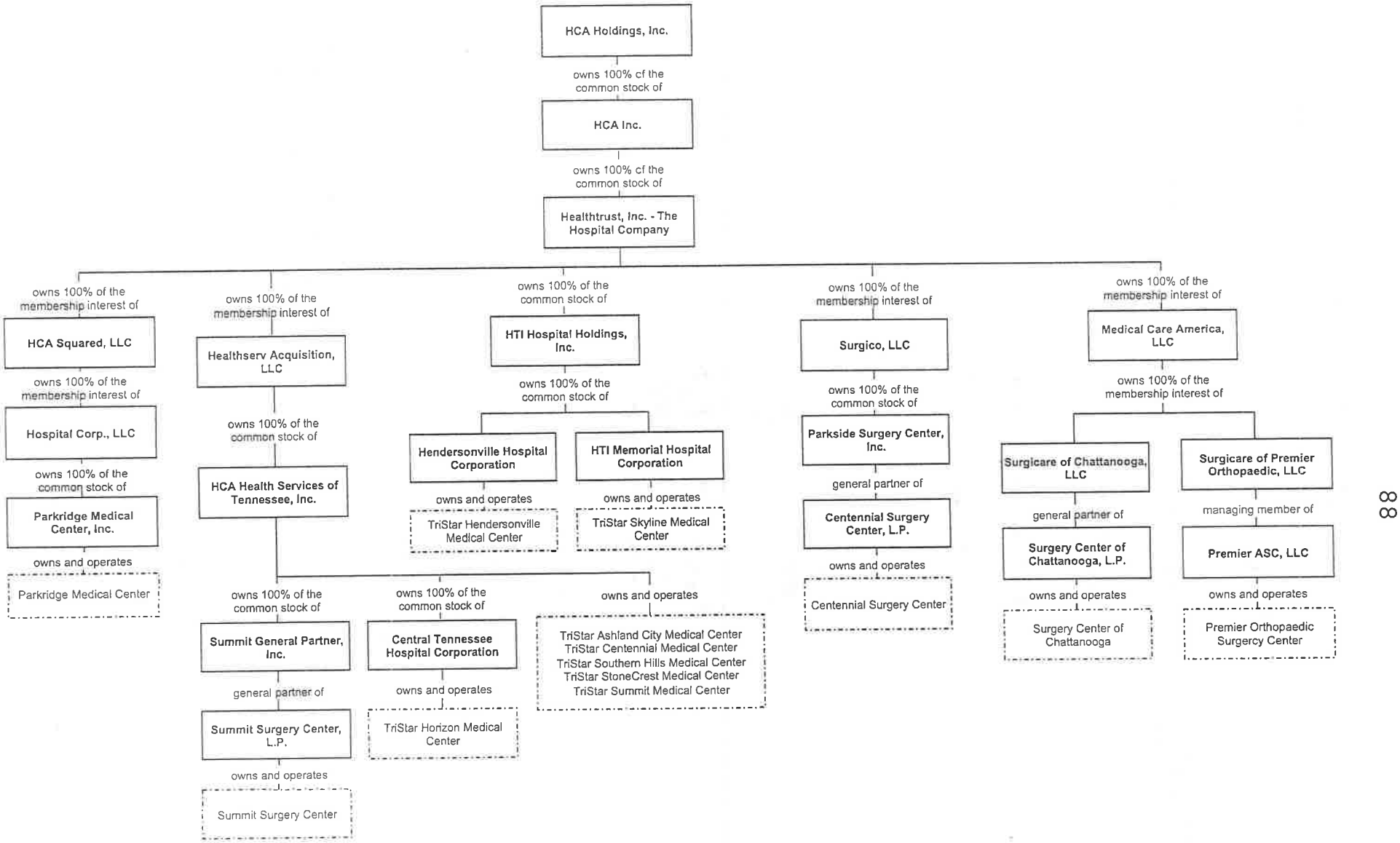
Rebecca J. Patchin, M.D.
Chair, Board of Commissioners

Organization ID #7[illegible]
Print/Reprint Date: 11/5/13

Mark R. Chassin, MD, FACP, MPP, MPH
President

The Joint Commission is an independent, not-for-profit, national body that oversees the safety and quality of health care and other services provided in certified organizations. Information about certified organizations may be provided directly to The Joint Commission at 1-800-994-6610. Information regarding certification and the certification performance of individual organizations can be obtained through The Joint Commission's web site at www.jointcommission.org

AMA AMERICAN MEDICAL ASSOCIATION

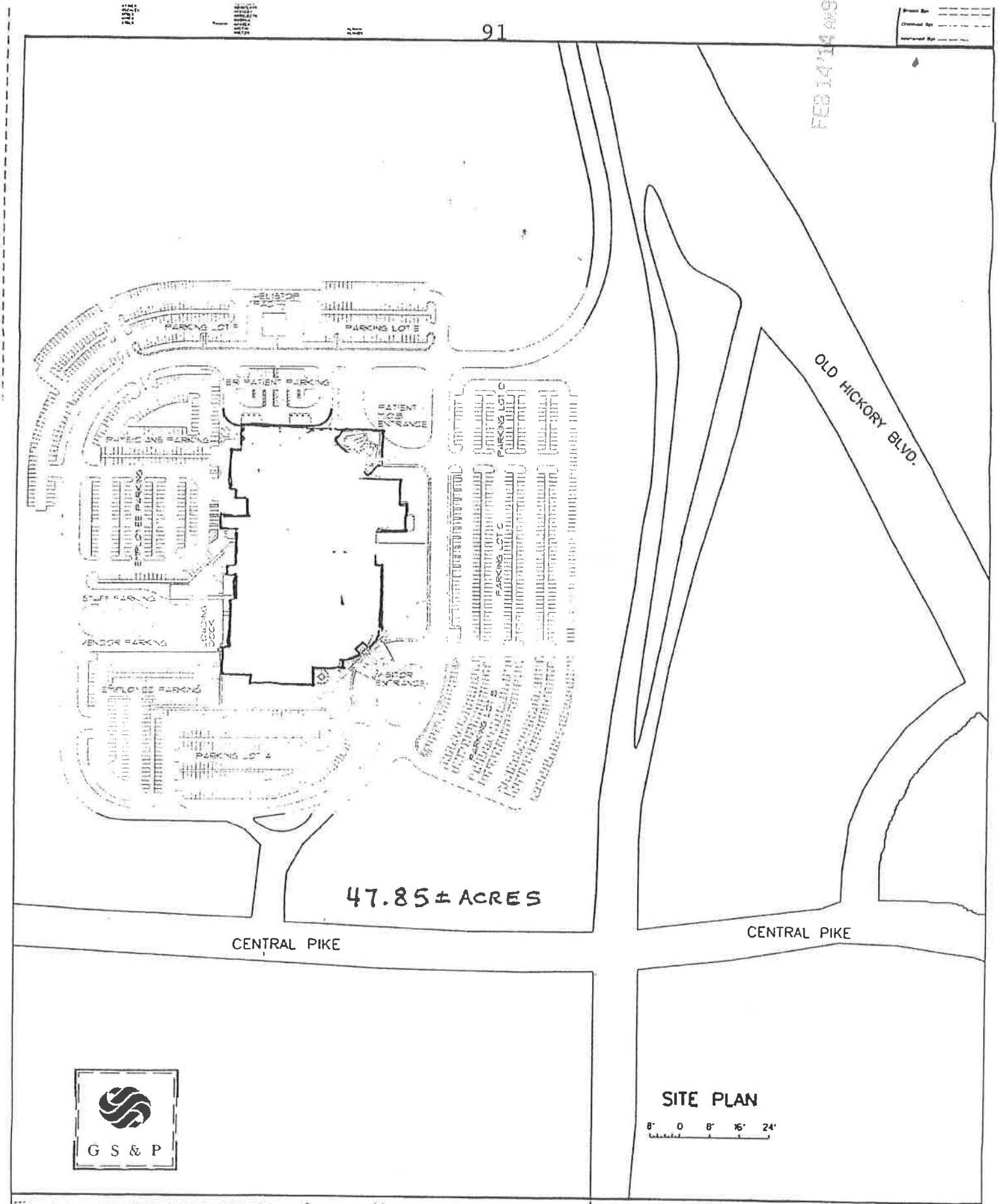

HCA Holdings, Inc.
owns 100% of the common stock of
HCA Inc.
owns 100% of the common stock of
Healthtrust, Inc. - The Hospital Company
owns 100% of the membership interest of
HCA Squared, LLC
owns 100% of the membership interest of
Hospital Corp., LLC
owns 100% of the common stock of
Parkridge Medical Center, Inc.
owns and operates
Parkridge Medical Center
owns 100% of the membership interest of
Healthserv Acquisition, LLC
owns 100% of the common stock of
HCA Health Services of Tennessee, Inc.
owns 100% of the common stock of
Summit General Partner, Inc.
general partner of
Summit Surgery Center, L.P.
owns and operates
Summit Surgery Center
owns 100% of the common stock of
Central Tennessee Hospital Corporation
owns and operates
TriStar Horizon Medical Center
owns and operates
TriStar Ashland City Medical Center
TriStar Centennial Medical Center
TriStar Southern Hills Medical Center
TriStar StoneCrest Medical Center
TriStar Summit Medical Center
owns 100% of the common stock of
HTI Hospital Holdings, Inc.
owns 100% of the common stock of
Hendersonville Hospital Corporation
owns and operates
TriStar Hendersonville Medical Center
HTI Memorial Hospital Corporation
owns and operates
TriStar Skyline Medical Center
owns 100% of the membership interest of
Surgico, LLC
owns 100% of the common stock of
Parkside Surgery Center, Inc.
general partner of
Centennial Surgery Center, L.P.
owns and operates
Centennial Surgery Center
owns 100% of the membership interest of
Medical Care America, LLC
owns 100% of the membership interest of
Surgicare of Chattanooga, LLC
general partner of
Surgery Center of Chattanooga, L.P.
owns and operates
Surgery Center of Chattanooga
Surgicare of Premier Orthopaedic, LLC
managing member of
Premier ASC, LLC
owns and operates
Premier Orthopaedic Surgercy Center

TENNESSEE FACILITIES OWNED BY HCA, INC.

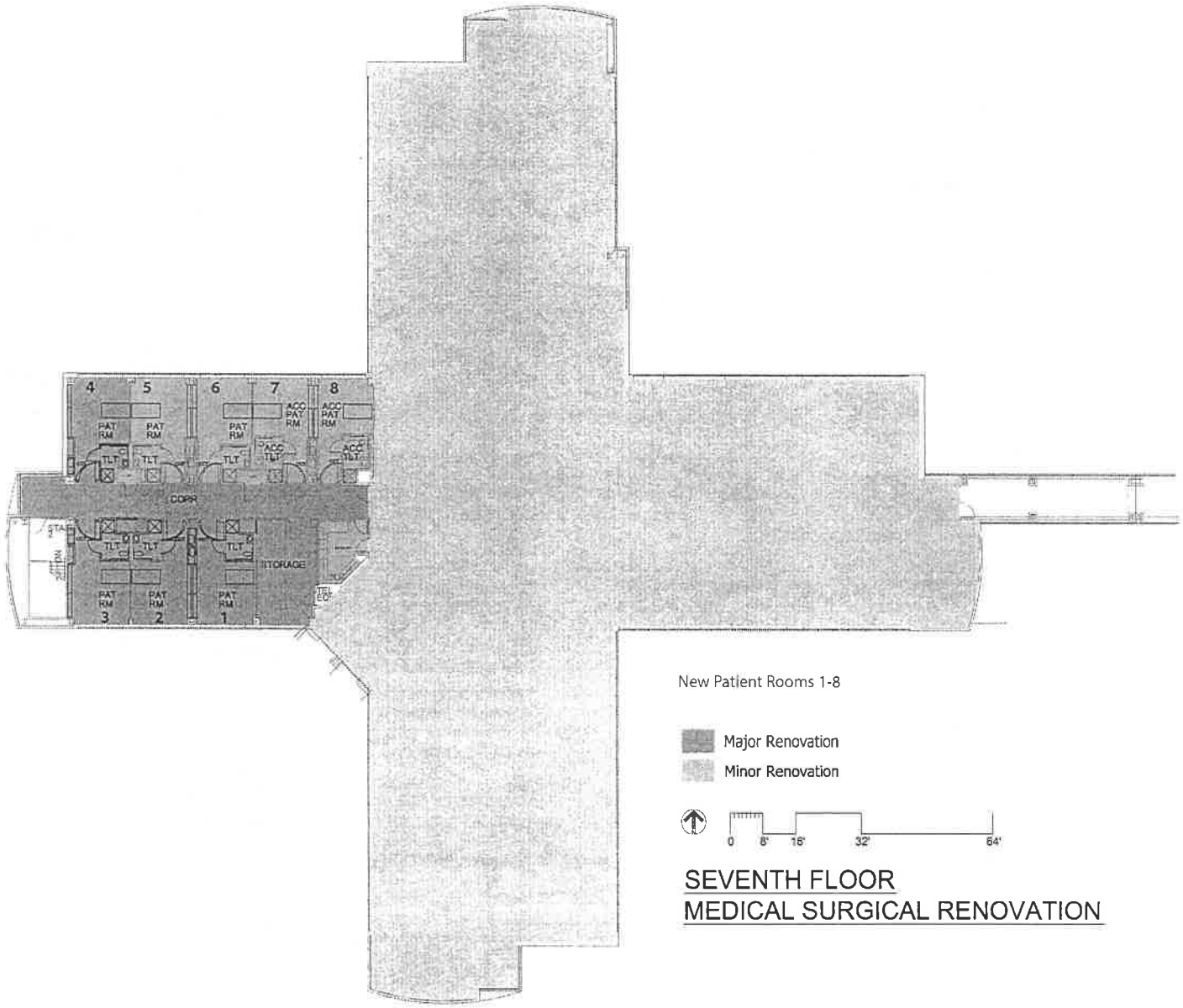
Centennial Medical Center	2300 Patterson Str		Nashville	TN	37203
Parthenon Pavilion	2401 Parman Place		Nashville	TN	37203
Sarah Cannon Cancer Center	250 25th Avenue North	Suite 110	Nashville	TN	37203
Sarah Cannon Research Institute	3322 West End Avenue	Suite 900	Nashville	TN	37203
Women's Hospital	2221 Murphy Avenue		Nashville	TN	37203
Centennial Surgery Center	345 23rd Ave N	Suite 201	Nashville	TN	37203-1524
Greenview Regional Hospital	1801 Ashley Circle		Bowling Green	KY	42104-9024
Hendersonville Medical Center	355 New Shackle Island Road		Hendersonville	TN	37075
Horizon Medical Center	111 Highway 70 East		Dickson	TN	37055
Natchez Imaging	101 Natchez Park Drive		Dickson	TN	37055
Radiation Oncology @ SCCC	105 Natchez Park Drive		Dickson	TN	37055
TN Oncology @ SCCC	103 Natchez Park Drive,		Dickson	TN	37055
Parkridge East Hospital	941 Spring Creek Road		Chattanooga	TN	37412
Parkridge Medical Center	2333 McCallie Avenue		Chattanooga	TN	37404
Parkridge Valley Hospital	2200 Morris Hill Road		Chattanooga	TN	37421
Portland Medical Center	105 Redbud Drive		Portland	TN	37148
Skyline Medical Center	3441 Dickerson Pike		Nashville	TN	37207
Skyline Madison Campus	500 Hospital Drive		Madison	TN	37115
Southern Hills Medical Center	391 Wallace Road		Nashville	TN	37211
Southern Hills Surgical Center	360 Wallace Road		Nashville	TN	37212
StoneCrest Medical Center	200 StoneCrest Boulevard		Smyrna	TN	37167
Summit Medical Center	5655 Frist Boulevard		Hermitage	TN	37076
Summit Surgery Center	3901 Central Pike	Suite 152	Hermitage	TN	37076

FEB. 27, 2012

B.III.--Plot Plan


91
OLD HICKORY BLVD.
CENTRAL PIKE
CENTRAL PIKE
47.85± ACRES
PARKING LOT B
PARKING LOT E
PARKING LOT C
PARKING LOT A
EMPLOYEE PARKING
VENDOR PARKING
LOADING DOCK
VISITOR ENTRANCE
PATIENT DROP-OFF
PATIENT ENTRANCE
SITE PLAN
8' 0 8' 16' 24'
G S & P
PRELIMINARY NOT FOR CONSTRUCTION
REVISIONS
SUMMIT MEDICAL CENTER
GRESHAM SMITH AND PARTNERS
Design Services For The Built Environment
G S & P

B.IV.--Floor Plan



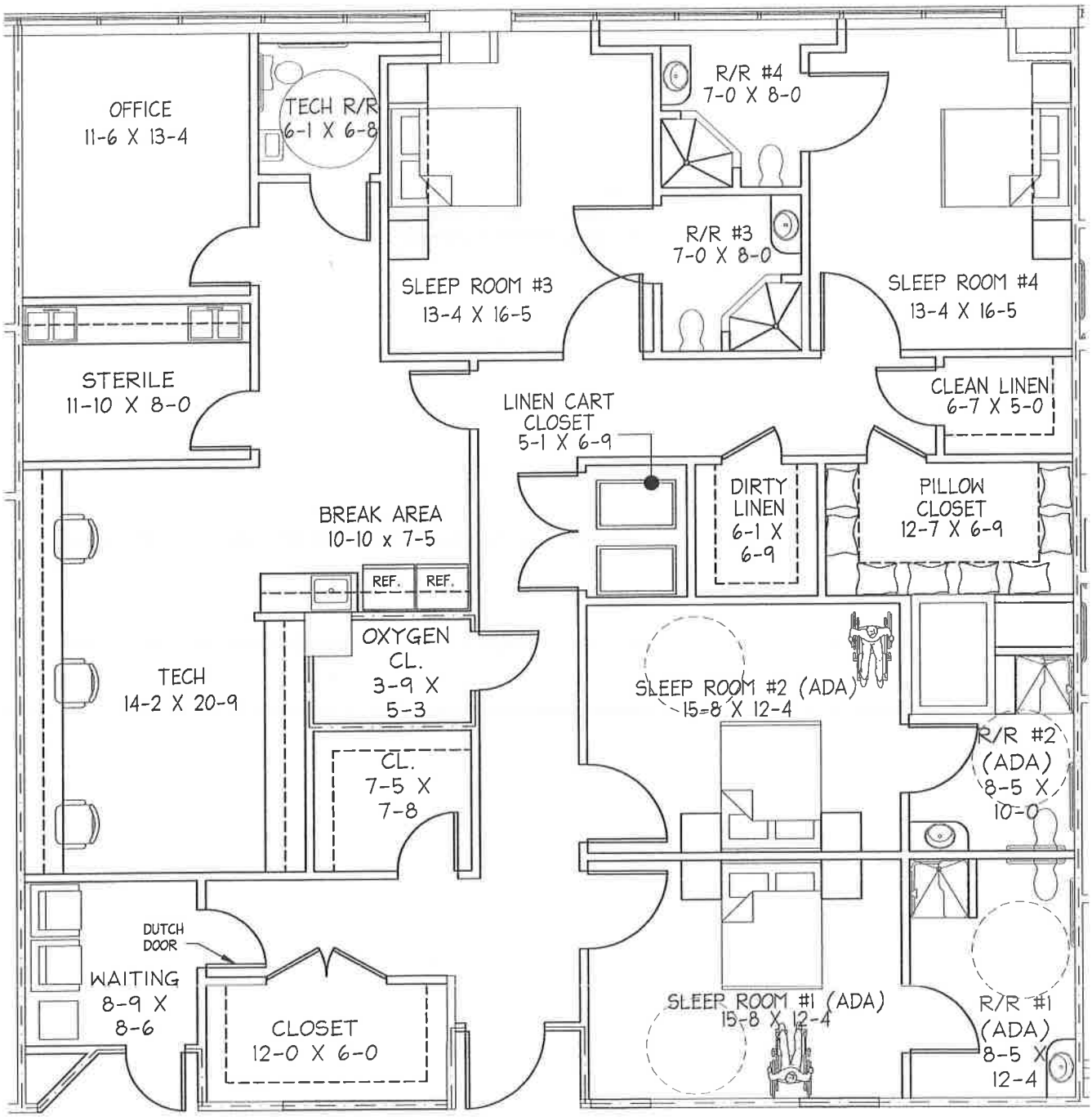
SEVENTH FLOOR
MEDICAL SURGICAL RENOVATION

TriStar Summit Medical Center
Hermitage, TN

Seventh Floor | Proposed
MED SURG

G S & P

PROJECT No.
29963.00
January 6, 2014



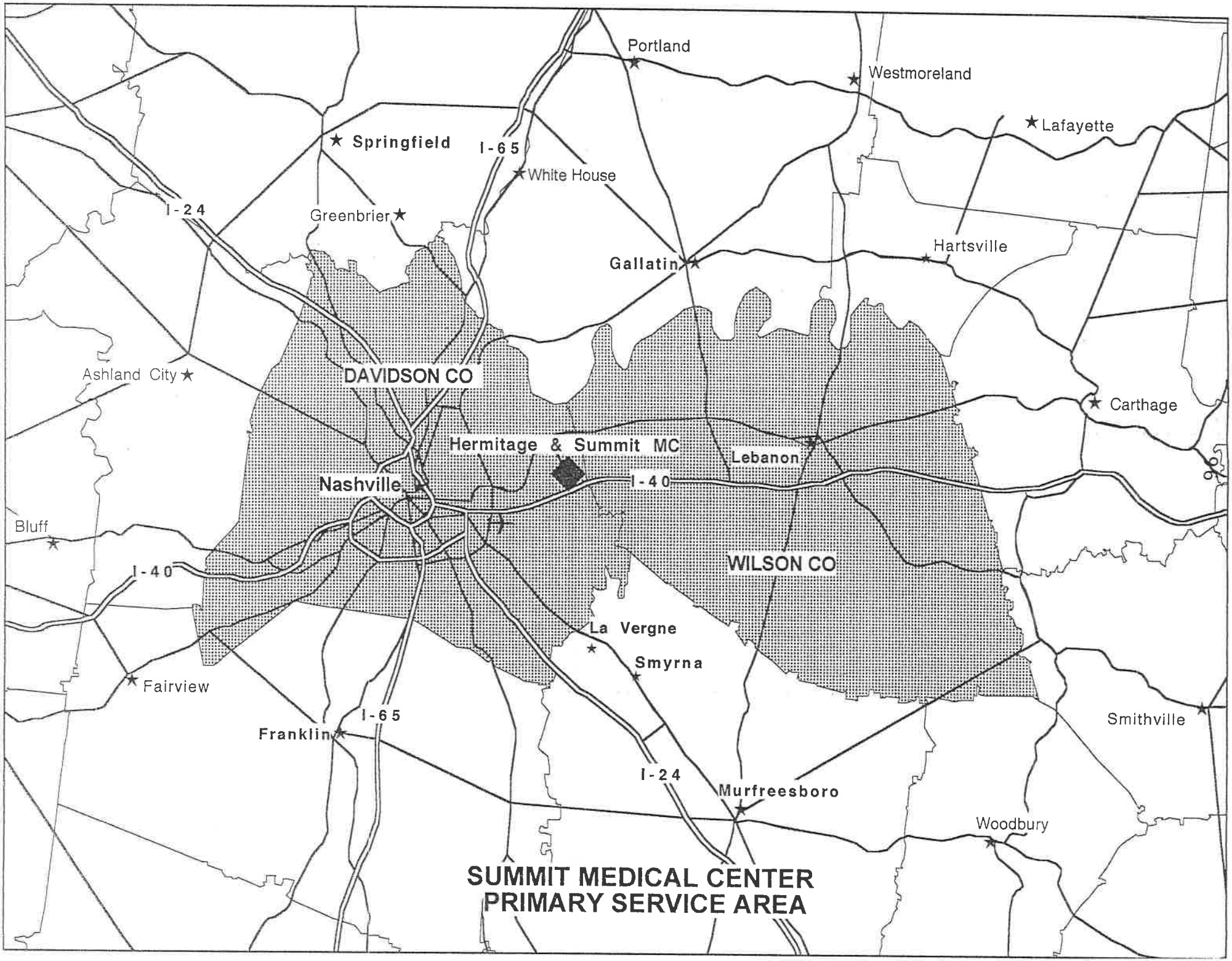
SUMMIT SLEEP LAB
PRELIMINARY 1 - 2,936 U.S.F.

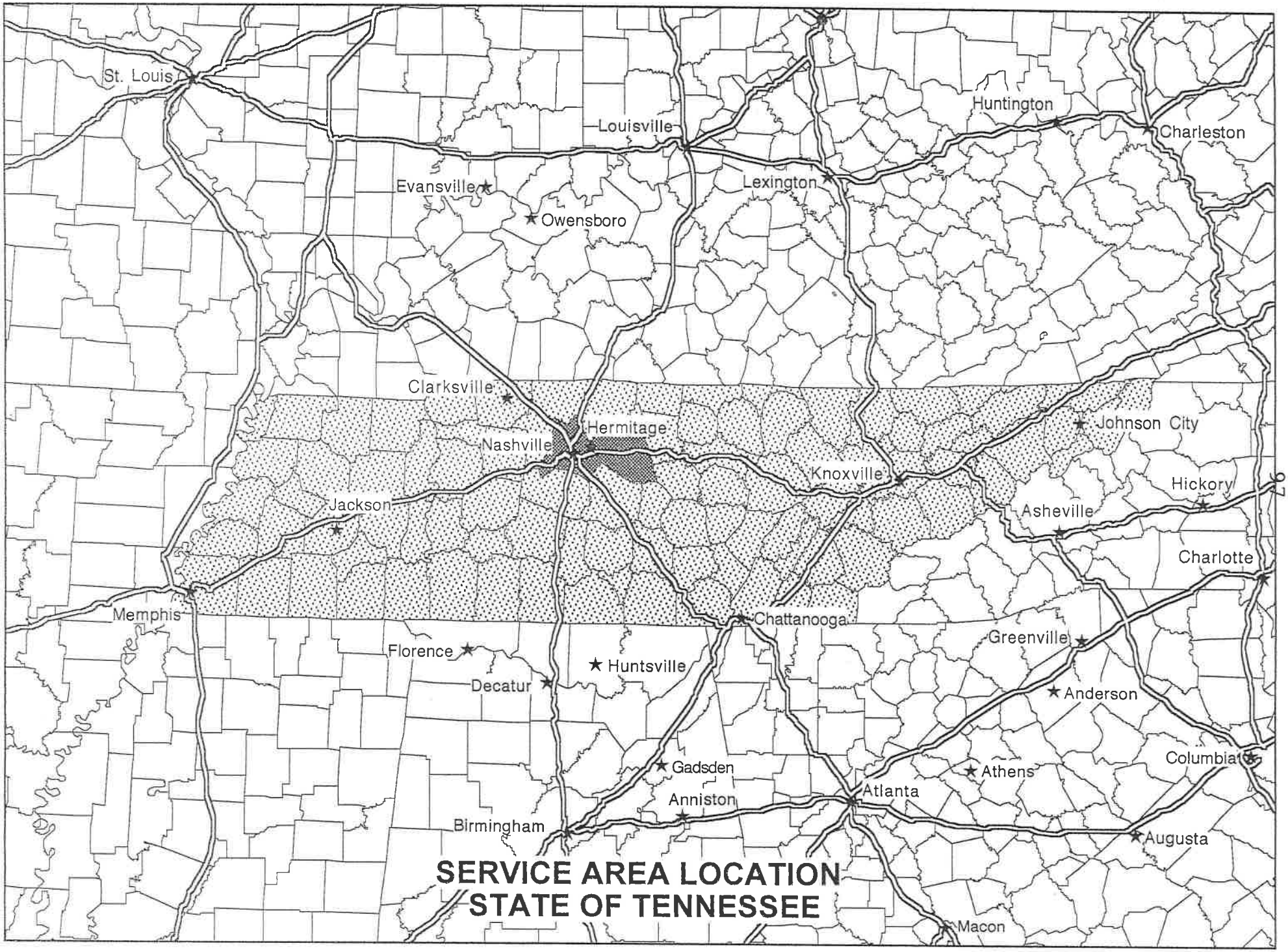
ARCHITECTURAL ENVIRONMENTS
FILE: AE14-001
SCALE: 1/8" = 1'-0"
2,936 U.S.F.
9010 OVERLOOK BLVD. SUITE C-3 . BRENTWOOD, TN T - 615-628-4429 F - 615-628-4425 . www.aenashville.com

N

SUMMIT MOB I
5651 FRIST BLVD.
HERMITAGE, TENNESSEE

C, Need--3
Service Area Maps


Portland
Westmoreland
Lafayette
Springfield
I-65
White House
I-24
Greenbrier
Hartsville
Gallatin
Ashland City
DAVIDSON CO
Carthage
Hermitage & Summit MC
Lebanon
Nashville
I-40
Bluff
I-40
WILSON CO
La Vergne
Smyrna
Fairview
I-65
Franklin
Smithville
I-24
Murfreesboro
Woodbury
SUMMIT MEDICAL CENTER
PRIMARY SERVICE AREA


St. Louis
Louisville
Huntington
Charleston
Evansville
Owensboro
Lexington
Clarksville
Hermitage
Nashville
Johnson City
Knoxville
Hickory
Jackson
Asheville
Charlotte
Memphis
Chattanooga
Greenville
Florence
Huntsville
Decatur
Anderson
Columbia
Gadsden
Athens
Atlanta
Anniston
Birmingham
Augusta
Macon
SERVICE AREA LOCATION
STATE OF TENNESSEE

C, Economic Feasibility--1
Documentation of Construction Cost Estimate

GRESHAM
SMITH AND
PARTNERS

February 4, 2014

Mr. Jeff Whitehorn, CHE
Chief Executive Officer
Summit Medical Center
5655 Frist Boulevard
Hermitage, TN 37076

Subject; **Verification of Construction Cost Estimates**
7th Floor 8-Bed Med/Surg Unit
Summit Medical Center
Hermitage, Tennessee
GS&P Project No. 29963.00 / 0.1

Gresham, Smith and Partners, Inc., an architectural/engineering firm in Nashville, Tennessee, has reviewed the cost data provided by HCA for the above-referenced project, for which this firm has provided a preliminary design. The stated renovated construction cost for this 4,406 SF area is $1,161,133. [In providing options of probably construction cost, the Client understands that the Consultant has no control over the cost or availability of labor, equipment or materials, or over market conditions or the Contractor's method of pricing, and that the Consultant's options of probable construction costs are made on the basis of the Consultant's professional judgment and experience. The Consultant makes no warrant, express or implied, that the bids or the negotiated cost of the Work will not vary from the Consultant's opinion of probable construction cost.]

It is our opinion that at this time, the projected renovated construction cost is reasonable for this type and size of project and compares appropriately with similar projects in this market.

The building codes applicable to this project will be:

International Building Code, 2006
NFPA 101 Life Safety Code, 2006
FGI Guidelines for Design & Construction of Healthcare Facilities, 2010
ANSI-117.1, 2003

Sincerely,

Kenneth A. Priest, AIA, NCARB, LEED AP
License No. 16010

bma

C, Economic Feasibility--2
Documentation of Availability of Funding

TriStar Health

TriStarHealth.com
110 Winners Circle, First Floor
Brentwood, TN 37027
(615) 886-4900

February 10, 2014

Melanie M. Hill, Executive Director
Tennessee Health Services and Development Agency
Andrew Jackson State Office Building, Suite 850
500 Deaderick Street
Nashville, Tennessee 37243

RE: Summmit Medical Center CON Application for Eight Medical-Surgical Beds

Dear Mrs. Hill:

TriStar Summit Medical Center is applying for a Certificate of Need to add eight medical-surgical beds in an existing wing built for that purpose, on its seventh floor.

As Controller of the TriStar Health System, the HCA Division Office to which this facility belongs, I am writing to confirm that HCA Holdings, Inc. will provide through TriStar the approximately $1,813,000 in capital costs required to implement this project. HCA Holdings, Inc.'s financial statements are provided in the application.

Sincerely,

Bryan Shepherd
Controller
TriStar Division of HCA

C, Economic Feasibility--10
Financial Statements

F00025 - SUMMIT MED CTR-TOT HOS OPS - S031

Dec - 2013

1/30/2014 03:10:04 PM

Financial Statements - Income Statement

All Entities

Report ID: ALCFS008

Month								Year to Date						
Actual	Budget	Bud Var	Var %	Prior Year	PY Var	Var %		Actual	Budget	Bud Var	Var %	Prior Year	PY Var	Var %
							REVENUES							
6,876	6,710	165	2.47%	6,532	343	5.26%	Inpatient Revenue Routine Services	74,540	75,864	(1,325)	-1.75%	70,651	3,889	5.50%
38,816	35,869	2,947	8.22%	31,782	7,034	22.13%	Inpatient Revenue Ancillary Services	396,627	382,226	14,401	3.77%	349,226	47,401	13.57%
45,692	42,580	3,113	7.31%	38,315	7,378	19.26%	Inpatient Gross Revenue	471,166	458,090	13,076	2.85%	419,876	51,290	12.22%
36,649	33,573	3,076	9.16%	29,710	6,939	23.36%	Outpatient Gross Revenue	383,130	371,149	11,980	3.23%	335,856	47,274	14.08%
82,342	76,153	6,189	8.13%	68,025	14,317	21.05%	Total Patient Revenue	854,296	829,240	25,056	3.02%	755,732	98,563	13.04%
87	91	(4)	-4.32%	81	6	7.50%	Other Revenue	1,175	1,144	32	2.77%	1,141	35	3.05%
82,429	76,244	6,185	8.11%	68,106	14,323	21.03%	Gross Revenue	855,471	830,383	25,088	3.02%	756,873	98,598	13.03%
							DEDUCTIONS							
20,509	19,188	1,321	6.89%	15,797	4,713	29.83%	Total CY CA - Medicare (1,2)	206,008	205,504	503	0.24%	185,434	20,574	11.09%
59	91	(32)	-35.32%	136	(77)	-56.69%	Total CY CA - Medicaid (3)	930	973	(44)	-4.50%	954	(24)	-2.53%
572	619	(47)	-7.63%	625	(53)	-8.42%	Total CY CA - Champus (6)	7,082	6,725	357	5.31%	6,137	945	15.39%
				(1,175)	1,175	100.00%	Prior Year Contractuals	(1,116)	(935)	(181)	-19.39%	(1,958)	842	42.99%
36,950	33,846	3,104	9.17%	29,814	7,136	23.94%	Total CY CA - Mgd Care (7,8,9,12,13)	381,070	363,464	17,606	4.84%	323,353	57,717	17.85%
915	655	261	39.87%	257	659	256.44%	Charity	5,880	7,128	(1,249)	-17.52%	5,391	489	9.07%
1,517	598	919	153.74%	1,454	63	4.33%	Bad Debt	13,054	19,600	(6,546)	-33.40%	18,488	(5,434)	-29.39%
5,276	5,355	(79)	-1.47%	4,855	422	8.69%	Other Deductions	65,704	57,833	7,870	13.61%	52,987	12,717	24.00%
65,799	60,352	5,447	9.03%	51,762	14,037	27.12%	Total Revenue Deductions (incl Bad Debt)	678,610	660,293	18,317	2.77%	590,786	87,824	14.87%
16,630	15,892	738	4.64%	16,344	286	1.75%	Cash Revenue	176,861	170,090	6,771	3.98%	166,087	10,774	6.49%
							OPERATING EXPENSES							
4,083	3,996	88	2.20%	3,943	140	3.56%	Salaries and Wages	45,542	45,457	85	0.19%	44,152	1,391	3.15%
90	13	77	610.76%	8	82	1,052.15%	Contract Labor	388	148	240	161.77%	138	251	182.32%
835	1,024	(189)	-18.44%	935	(100)	-10.73%	Employee Benefits	12,438	12,874	(436)	-3.39%	12,542	(104)	-0.83%
2,625	2,072	553	26.69%	1,926	698	36.26%	Supply Expense	27,425	24,388	3,037	12.45%	24,857	2,568	10.33%
337	357	(21)	-5.76%	278	59	21.16%	Professional Fees	3,921	4,249	(328)	-7.71%	3,778	144	3.80%
1,384	1,300	84	6.48%	1,411	(26)	-1.86%	Contract Services	15,259	15,551	(291)	-1.87%	15,868	(608)	-3.83%
375	308	67	21.62%	308	67	21.87%	Repairs and Maintenance	3,927	3,811	116	3.06%	3,742	185	4.94%
183	149	34	22.96%	142	41	28.77%	Rents and Leases	1,910	1,797	113	6.26%	1,712	198	11.57%
128	169	(41)	-24.30%	172	(44)	-25.51%	Utilities	1,956	2,114	(158)	-7.48%	2,035	(80)	-3.91%
(269)	(304)	35	11.48%	(242)	(28)	-11.45%	Insurance	2,225	2,202	23	1.04%	2,281	(56)	-2.43%
							Investment Income							
(97)	120	(217)	-180.54%	(6)	(90)	1,464.51%	Non-Income Taxes	1,305	1,441	(136)	-9.44%	1,339	(34)	-2.55%
290	243	47	19.34%	466	(176)	-37.80%	Other Operating Expense	2,084	2,447	(363)	-14.84%	2,349	(265)	-11.29%
9,964	9,446	518	5.48%	9,341	623	6.67%	Cash Expense	118,380	116,479	1,901	1.63%	114,792	3,589	3.13%
6,666	6,446	220	3.41%	7,003	(337)	-4.82%	EBITDA	58,481	53,611	4,869	9.08%	51,295	7,185	14.01%
							CAPITAL AND OTHER COSTS							
622	600	22	3.62%	626	(4)	-0.72%	Depreciation & Amortization	7,010	7,354	(343)	-4.67%	7,489	(479)	-6.40%
							Other Non-Operating Expenses							
(1,172)	(1,168)	(4)	-0.35%	(1,008)	(164)	-16.27%	Interest Expense	(12,963)	(12,627)	(336)	-2.66%	(11,171)	(1,792)	-16.04%
1,154	1,141	13	1.17%	(1,186)	2,341	197.31%	Mgmt Fees and Markup Cost	11,618	13,731	(2,112)	-15.38%	9,701	1,917	19.76%
							Minority Interest							
604	573	31	5.41%	(1,568)	2,172	138.52%	Total Capital and Others	5,666	8,457	(2,791)	-33.01%	6,020	(354)	-5.88%
6,062	5,873	189	3.22%	8,571	(2,510)	-29.28%	Pretax Income	52,815	45,154	7,661	16.97%	45,275	7,540	16.65%
							TAXES ON INCOME							
							Federal Income Taxes							
							State Income Taxes							
							Total Taxes on Income							
6,062	5,873	189	3.22%	8,571	(2,510)	-29.28%	Net Income	52,815	45,154	7,661	16.97%	45,275	7,540	16.65%

Month				Year to Date		
Begin	Change	Ending		Begin	Change	Ending
			CURRENT ASSETS			
29,317	25,256	54,573	Cash & Cash Equivalents	32,998	21,575	54,573
			Marketable Securities			
			PATIENT ACCOUNTS RECEIVABLES			
49,081,573	2,058,231	51,139,804	Patient Receivables	47,786,863	3,352,941	51,139,804
			Less Allow for Govt Receivables			
-24,525,425	-543,409	-25,068,834	Less Allow - Bad Debt	-25,859,971	791,137	-25,068,834
24,556,148	1,514,822	26,070,970	Net Patient Receivables	21,926,892	4,144,078	26,070,970
			FINAL SETTLEMENTS			
15,937	0	15,937	Due to/from Govt Programs	-260,961	276,898	15,937
			Allowances Due Govt Programs			
15,937	0	15,937	Net Final Settlements	-260,961	276,898	15,937
24,572,085	1,514,822	26,086,907	Net Accounts Receivables	21,665,931	4,420,976	26,086,907
5,617,166	130,380	5,747,546	Inventories	4,983,833	763,713	5,747,546
814,134	114,384	928,518	Prepaid Expenses	2,708,029	-1,779,511	928,518
33,865	10,131	43,996	Other Receivables	88,971	-44,975	43,996
31,066,567	1,794,973	32,861,540	Total Current Assets	29,479,762	3,381,778	32,861,540
			PROPERTY, PLANT & EQUIPMENT			
6,124,510	0	6,124,510	Land	6,124,510	0	6,124,510
49,192,391	271,096	49,463,487	Bldgs & Improvements	48,481,104	982,383	49,463,487
70,280,588	148,156	70,428,744	Equipment - Owned	85,019,890	-14,591,146	70,428,744
2,164,471	0	2,164,471	Equipment - Capital Leases	2,164,472	-1	2,164,471
277,851	-270,963	6,888	Construction in Progress	121,260	-114,372	6,888
128,039,811	148,289	128,188,100	Gross PP&E	141,911,236	-13,723,136	128,188,100
-84,004,571	-570,734	-84,575,305	Less Accumulated Depreciation	-94,352,235	9,776,930	-84,575,305
44,035,240	-422,445	43,612,795	Net PP&E	47,559,001	-3,946,206	43,612,795
			OTHER ASSETS			
			Investments			
0	0	0	Notes Receivable	0	0	0
10,027,657	0	10,027,657	Intangible Assets - Net	10,027,657	0	10,027,657
			Investments in Subsidiaries			
			Other Assets			
10,027,657	0	10,027,657	Total Other Assets	10,027,657	0	10,027,657
85,129,464	1,372,528	86,501,992	Grand Total Assets	87,066,420	-564,428	86,501,992
			CURRENT LIABILITIES			
3,317,384	173,557	3,490,941	Accounts Payable	5,422,153	-1,931,212	3,490,941
4,237,102	598,229	4,835,331	Accrued Salaries	4,601,670	233,661	4,835,331
1,657,083	-67,489	1,589,594	Accrued Expenses	1,533,380	56,214	1,589,594
14,169	-202	13,967	Accrued Interest	16,271	-2,304	13,967
			Distributions Payable			
726,158	-37,014	689,144	Curr Port - Long Term Debt	1,046,455	-357,311	689,144
11,515	6,245	17,760	Other Current Liabilities	14,390	3,370	17,760
			Income Taxes Payable			
9,963,411	673,326	10,636,737	Total Current Liabilities	12,634,319	-1,997,582	10,636,737
			LONG TERM DEBT			
2,494,269	-52,370	2,441,899	Capitalized Leases	3,131,043	-689,144	2,441,899
-272,018,151	-5,309,878	-277,328,029	Inter/Intra Company Debt	-244,119,609	-33,208,420	-277,328,029
			Other Long Term Debts			
-269,523,882	-5,362,248	-274,886,130	Total Long Term Debts	-240,988,566	-33,897,564	-274,886,130
			DEFFERED CREDITS AND OTHER LIAB			
			Professional Liab Risk			
			Deferred Incomes Taxes			
72,084	-296	71,788	Long-Term Obligations	91,220	-19,432	71,788
72,084	-296	71,788	Total Other Liabilities & Def	91,220	-19,432	71,788
			EQUITY			
1,000	0	1,000	Common Stock - par value	1,000	0	1,000
23,562,553	0	23,562,553	Capital in Excess of par value	23,562,553	0	23,562,553
274,301,469	0	274,301,469	Retained Earnings - current yr	291,765,889	-17,464,420	274,301,469
46,752,829	6,061,746	52,814,575	Net Income Current Year		52,814,575	52,814,575
			Distributions			
			Other Equity			
344,617,851	6,061,746	350,679,597	Total Equity	315,329,447	35,350,150	350,679,597
85,129,464	1,372,528	86,501,992	Total Liabilities and Equity	87,066,420	-564,428	86,501,992

	8,036	91.0	7,879	93.4
Income before income taxes	800	9.0	555	6.6
Provision for income taxes	246	2.7	128	1.5
Net income	554	6.3	427	5.1
Net income attributable to noncontrolling interests	130	1.5	113	1.4
Net income attributable to HCA Holdings, Inc.	$424	4.8	$314	3.7
Diluted earnings per share	$0.92		$0.68	
Shares used in computing diluted earnings per share (000)	458,535		461,131	
Comprehensive income attributable to HCA Holdings, Inc.	$541		$297	

HCA Holdings, Inc.
Condensed Consolidated Comprehensive Income Statements
For the Years Ended December 31, 2013 and 2012
(Dollars in millions, except per share amounts)

	2013		2012	
	Amount	Ratio	Amount	Ratio
Revenues before provision for doubtful accounts	$38,040		$36,783	
Provision for doubtful accounts	3,858		3,770	
Revenues	34,182	100.0%	33,013	100.0%
Salaries and benefits	15,646	45.8	15,089	45.7
Supplies	5,970	17.5	5,717	17.3
Other operating expenses	6,237	18.2	6,048	18.3
Electronic health record incentive income	(216)	(0.6)	(336)	(1.0)
Equity in earnings of affiliates	(29)	(0.1)	(36)	(0.1)
Depreciation and amortization	1,753	5.1	1,679	5.1
Interest expense	1,848	5.4	1,798	5.4
Losses (gains) on sales of facilities	10	-	(15)	-
Loss on retirement of debt	17	0.1	-	-
Legal claim costs	-	-	175	0.5
	31,236	91.4	30,119	91.2
Income before income taxes	2,946	8.6	2,894	8.8
Provision for income taxes	950	2.8	888	2.7
Net income	1,996	5.8	2,006	6.1
Net income attributable to noncontrolling interests	440	1.2	401	1.2
Net income attributable to HCA Holdings, Inc.	$1,556	4.6	$1,605	4.9
Diluted earnings per share	$3.37		$3.49	
Shares used in computing diluted earnings per share (000)	461,913		459,403	
Comprehensive income attributable to HCA Holdings, Inc.	$1,756		$1,588	

HCA Holdings, Inc.
Supplemental Non-GAAP Disclosures
Operating Results Summary
(Dollars in millions, except per share amounts)

For the Years

	Fourth Quarter Ended December 31,			
	2013	2012	2013	2012
Revenues	**$8,836**	$8,434	**$34,182**	$33,013
Net income attributable to HCA Holdings, Inc.	**$424**	$314	**$1,556**	$1,605
Losses (gains) on sales of facilities (net of tax)	**(2)**	(6)	**7**	(9)
Loss on retirement of debt (net of tax)	**-**	-	**11**	-
Legal claim costs (net of tax)	**-**	110	**-**	110
Net income attributable to HCA Holdings, Inc., excluding losses (gains) on sales of facilities, loss on retirement of debt and legal claim costs (a)	**422**	418	**1,574**	1,706
Depreciation and amortization	**461**	425	**1,753**	1,679
Interest expense	**456**	462	**1,848**	1,798
Provision for income taxes	**245**	188	**959**	947
Net income attributable to noncontrolling interests	**130**	113	**440**	401
Adjusted EBITDA (a)	**$1,714**	$1,606	**$6,574**	$6,531
Diluted earnings per share:				
Net income attributable to HCA Holdings, Inc.	**$0.92**	$0.68	**$3.37**	$3.49
Losses (gains) on sales of facilities	**-**	(0.01)	**0.02**	(0.02)
Loss on retirement of debt	**-**	-	**0.02**	-
Legal claim costs	**-**	0.24	**-**	0.24
Net income attributable to HCA Holdings, Inc., excluding losses (gains) on sales of facilities, loss on retirement of debt and legal claim costs (a)	**$0.92**	$0.91	**$3.41**	$3.71
Shares used in computing diluted earnings per share (000)	**458,535**	461,131	**461,913**	459,403

(a) Net income attributable to HCA Holdings, Inc., excluding losses (gains) on sales of facilities, loss on retirement of debt and legal claim costs, and Adjusted EBITDA should not be considered as measures of financial performance under generally accepted accounting principles ("GAAP"). We believe net income attributable to HCA Holdings, Inc., excluding losses (gains) on sales of facilities, loss on retirement of debt and legal claim costs, and Adjusted EBITDA are important measures that supplement discussions and analysis of our results of operations. We believe it is useful to investors to provide disclosures of our results of operations on the same basis used by management. Management relies upon net income attributable to HCA Holdings, Inc., excluding losses (gains) on sales of facilities, loss on retirement of debt and legal claim costs, and Adjusted EBITDA as the primary measures to review and assess operating performance of its hospital facilities and their management teams.

Management and investors review both the overall performance (including:net income attributable to HCA Holdings)(including:Inc.)(including:excluding losses (gains) on sales of facilities, loss on retirement of debt and legal claim costs, and GAAP net income attributable to HCA Holdings, Inc.) and operating performance (Adjusted EBITDA) of our health care facilities. Adjusted EBITDA and the Adjusted EBITDA margin (Adjusted EBITDA divided by revenues) are utilized by management and investors to compare our current operating results with the corresponding periods during the previous year and to compare our operating results with other companies in the health care industry. It is reasonable to expect that losses (gains) on sales of facilities and losses on retirement of debt will occur in future periods, but the amounts recognized can vary significantly from period to period, do not directly relate to the ongoing operations of our health care facilities and complicate period comparisons of our results of operations and operations comparisons with other health care companies.

Net income attributable to HCA Holdings, Inc., excluding losses (gains) on sales of facilities, loss on retirement of debt and legal claim costs, and Adjusted EBITDA are not measures of financial performance under GAAP and should not be considered as alternatives to net income attributable to HCA Holdings, Inc. as a measure of operating performance or cash flows from operating, investing and financing activities as a measure of liquidity. Because net income attributable to HCA Holdings, Inc., excluding losses (gains) on sales of facilities, loss on retirement of debt and legal claim costs, and Adjusted EBITDA are not measurements determined in accordance with GAAP and are susceptible to varying calculations, net income attributable to HCA Holdings, Inc., excluding losses (gains) on sales of facilities, loss on retirement of debt and legal claim costs, and Adjusted EBITDA, as presented, may not be comparable to other similarly titled measures presented by other companies.

HCA Holdings, Inc.
Condensed Consolidated Balance Sheets

(Dollars in millions)

	December 31, 2013	September 30, 2013	December 31, 2012
ASSETS			
Current assets:			
Cash and cash equivalents	**$414**	$484	$705
Accounts receivable, net	**5,208**	4,924	4,672
Inventories	**1,179**	1,135	1,086
Deferred income taxes	**489**	400	385
Other	**747**	828	915
Total current assets	**8,037**	7,771	7,763
Property and equipment, at cost	**31,073**	30,472	29,527
Accumulated depreciation	**(17,454)**	(17,150)	(16,342)
	13,619	13,322	13,185
Investments of insurance subsidiaries	**448**	402	515
Investments in and advances to affiliates	**121**	125	104
Goodwill and other intangible assets	**5,903**	5,832	5,539
Deferred loan costs	**237**	250	290
Other	**466**	691	679
	$28,831	$28,393	$28,075
LIABILITIES AND STOCKHOLDERS' DEFICIT			
Current liabilities:			
Accounts payable	**$1,803**	$1,582	$1,768
Accrued salaries	**1,193**	1,085	1,120
Other accrued expenses	**1,913**	1,764	1,849
Long-term debt due within one year	**786**	988	1,435
Total current liabilities	**5,695**	5,419	6,172
Long-term debt	**27,590**	27,389	27,495
Professional liability risks	**949**	959	973
Income taxes and other liabilities	**1,525**	1,670	1,776
EQUITY (DEFICIT)			
Stockholders' deficit attributable to HCA Holdings, Inc.	**(8,270)**	(8,376)	(9,660)
Noncontrolling interests	**1,342**	1,332	1,319
Total deficit	**(6,928)**	(7,044)	(8,341)
	$28,831	$28,393	$28,075

HCA Holdings, Inc.
Condensed Consolidated Statements of Cash Flows
For the Years Ended December 31, 2013 and 2012
(Dollars in millions)

	2013	2012
Cash flows from operating activities:		
Net income	**$1,996**	$2,006
Adjustments to reconcile net income to net cash provided by operating activities:		
Changes in operating assets and liabilities	**(4,272)**	(3,663)
Provision for doubtful accounts	**3,858**	3,770
Depreciation and amortization	**1,753**	1,679
Income taxes	**143**	96
Losses (gains) on sales of facilities	**10**	(15)
Loss on retirement of debt	**17**	-
Legal claim costs	**-**	175
Amortization of deferred loan costs	**55**	62

C, Orderly Development--7(C)
TDH Inspection & Plan of Correction

The Joint Commission

January 2, 2013

Jeff Whitehorn
Chief Executive Officer
Summit Medical Center
5655 Frist Boulevard
Hermitage, TN 37076

Joint Commission ID #: 7806
Program: Hospital Accreditation
Accreditation Activity: Measure of Success
Accreditation Activity Completed: 01/02/2013

Dear Mr. Whitehorn:

The Joint Commission would like to thank your organization for participating in the accreditation process. This process is designed to help your organization continuously provide safe, high-quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the accreditation process as a continuous standards compliance and operational improvement tool.

The Joint Commission is granting your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

- Comprehensive Accreditation Manual for Hospitals

This accreditation cycle is effective beginning May 26, 2012. The Joint Commission reserves the right to shorten or lengthen the duration of the cycle; however, the certificate and cycle are customarily valid for up to 36 months.

Please visit Quality Check® on The Joint Commission web site for updated information related to your accreditation decision.

We encourage you to share this accreditation decision with your organization's appropriate staff, leadership, and governing body. You may also want to inform the Centers for Medicare and Medicaid Services (CMS), state or regional regulatory services, and the public you serve of your organization's accreditation decision.

Please be assured that The Joint Commission will keep the report confidential, except as required by law. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

Mark Pelletier

Mark G.Pelletier, RN, MS

Chief Operating Officer

Division of Accreditation and Certification Operations

The Joint Commission

Summit Medical Center
5655 Frist Boulevard
Hermitage, TN 37076

Organization Identification Number: 7806

Evidence of Standards Compliance (45 Day) Submitted: 7/22/2012

Program(s)
Hospital Accreditation

Executive Summary

Hospital Accreditation : As a result of the accreditation activity conducted on the above date(s), there were no Requirements for Improvement identified.

You will have follow-up in the area(s) indicated below:

- Measure of Success (MOS) – A follow-up Measure of Success will occur in four (4) months.

If you have any questions, please do not hesitate to contact your Account Executive.

Thank you for collaborating with The Joint Commission to improve the safety and quality of care provided to patients.

The Joint Commission

Summit Medical Center
5655 Frist Boulevard
Hermitage, TN 37076

Organization Identification Number: 7806

Evidence of Standards Compliance (60 Day) Submitted: 8/16/2012

Program(s)
Hospital Accreditation

Executive Summary

Hospital Accreditation : As a result of the accreditation activity conducted on the above date(s), there were no Requirements for Improvement identified.

If you have any questions, please do not hesitate to contact your Account Executive.

Thank you for collaborating with The Joint Commission to improve the safety and quality of care provided to patients.

The Joint Commission

August 16, 2012

Re: # 7806
CCN: #440150
Program: Hospital
Accreditation Expiration Date: May 26, 2015

Jeff Whitehorn
Chief Executive Officer
Summit Medical Center
5655 Frist Boulevard
Hermitage, Tennessee 37076

Dear Mr. Whitehorn:

This letter confirms that your May 22, 2012 - May 25, 2012 unannounced full resurvey was conducted for the purposes of assessing compliance with the Medicare conditions for hospitals through The Joint Commission's deemed status survey process.

Based upon the submission of your evidence of standards compliance on July 22, 2012 and August 16, 2012, the areas of deficiency listed below have been removed. The Joint Commission is granting your organization an accreditation decision of Accredited with an effective date of May 26, 2012. We congratulate you on your effective resolution of these deficiencies.

§482.23 Condition of Participation: Nursing Services
§482.24 Condition of Participation: Medical Record Services
§482.25 Condition of Participation: Pharmaceutical Services
§482.41 Condition of Participation: Physical Environment

The Joint Commission is also recommending your organization for continued Medicare certification effective May 26, 2012. Please note that the Centers for Medicare and Medicaid Services (CMS) Regional Office (RO) makes the final determination regarding your Medicare participation and the effective date of participation in accordance with the regulations at 42 CFR 489.13. Your organization is encouraged to share a copy of this Medicare recommendation letter with your State Survey Agency.

This recommendation also applies to the following location(s):

Summit Medical Center
5655 Frist Blvd., Hermitage, TN, 37076

Summit Imaging
100 Physicians Way, Ste. 100 & 110, Lebanon, TN, 37087

Summit Outpatient Center
3901 Central Pike, Hermitage, TN, 37076

The Joint Commission

We direct your attention to some important Joint Commission policies. First, your Medicare report is publicly accessible as required by the Joint Commission's agreement with the Centers for Medicare and Medicaid Services. Second, Joint Commission policy requires that you inform us of any changes in the name or ownership of your organization, or health care services you provide.

Sincerely,

Mark Pelletier

Mark G. Pelletier, RN, MS
Chief Operating Officer
Division of Accreditation and Certification Operations

cc: CMS/Central Office/Survey & Certification Group/Division of Acute Care Services
CMS/Regional Office 4 /Survey and Certification Staff

Headquarters
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
630 792 5000 Voice

The Joint Commission

July 23, 2012

Jeff Whitehorn
Chief Executive Officer
Summit Medical Center
5655 Frist Boulevard
Hermitage, TN 37076

Joint Commission ID #: 7806
Program: Hospital Accreditation
Accreditation Activity: 45-day Evidence of Standards Compliance
Accreditation Activity Completed: 07/23/2012

Dear Mr. Whitehorn:

The Joint Commission would like to thank your organization for participating in the accreditation process. This process is designed to help your organization continuously provide safe, high - quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the accreditation process as a continuous standards compliance and operational improvement tool.

With that goal in mind, your organization received Requirement(s) for Improvement during its recent survey. These requirements have been summarized in the Accreditation Report provided by the survey team that visited your organization.

Please be assured that The Joint Commission will keep the report confidential, except as required by law. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Please visit Quality Check® on The Joint Commission web site for updated information related to your accreditation decision.

Sincerely,

Mark Pelletier

Mark G. Pelletier, RN, MS
Chief Operating Officer
Division of Accreditation and Certification Operations

The Joint Commission

Summit Medical Center
5655 Frist Boulevard
Hermitage, TN 37076

Organization Identification Number: 7806

Program(s)	**Survey Date(s)**
Hospital Accreditation	05/22/2012-05/25/2012

Executive Summary

As a result of the survey conducted on the above date(s), the following survey findings have been identified. Your official report will be posted to your organization's confidential extranet site. It will contain specific follow-up instructions regarding your survey findings.

If you have any questions, please do not hesitate to contact your Account Executive.

Thank you for collaborating with The Joint Commission to improve the safety and quality of care provided to patients.

DIRECT Impact Standards:

Program:	Hospital Accreditation Program	
Standards:	EC.02.05.07	EP6
	MM.04.01.01	EP13
	MM.05.01.01	EP8
	NPSG.03.04.01	EP2

INDIRECT Impact Standards:

Program:	Hospital Accreditation Program	
Standards:	EC.02.02.01	EP11
	EC.02.03.01	EP10
	EC.02.05.01	EP4
	EC.02.05.09	EP3
	EC.02.06.01	EP13
	LS.02.01.20	EP29
	LS.02.01.50	EP12
	MM.03.01.01	EP3,EP6
	RC.01.01.01	EP19
	RI.01.03.01	EP5

CoP: §482.23 **Tag:** A-0385 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.23 Condition of Participation: Nursing Services

The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse.

CoP Standard	Tag	Corresponds to	Deficiency
§482.23(c)(2)	A-0406	HAP - MM.04.01.01/EP13	Standard

CoP: §482.24 **Tag:** A-0431 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.24 Condition of Participation: Medical Record Services

The hospital must have a medical record service that has administrative responsibility for medical records. A medical record must be maintained for every individual evaluated or treated in the hospital.

CoP Standard	Tag	Corresponds to	Deficiency
§482.24(c)(1)	A-0450	HAP - RC.01.01.01/EP19	Standard
§482.24(c)(2)(v)	A-0466	HAP - RI.01.03.01/EP5	Standard

CoP: §482.25 **Tag:** A-0490 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.25 Condition of Participation: Pharmaceutical Services

The hospital must have pharmaceutical services that meet the needs of the patients. The institution must have a pharmacy directed by a registered pharmacist or a drug storage area under competent supervision. The medical staff is responsible for developing policies and procedures that minimize drug errors. This function may be delegated to the hospital's organized pharmaceutical service.

CoP Standard	Tag	Corresponds to	Deficiency
§482.25(b)(2)(i)	A-0502	HAP - MM.03.01.01/EP6, EP3	Standard

CoP: §482.41 **Tag:** A-0700 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.41 Condition of Participation: Physical Environment

The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.

CoP Standard	Tag	Corresponds to	Deficiency
§482.41(c)(2)	A-0724	HAP - EC.02.05.07/EP6	Standard
§482.41(c)(4)	A-0726	HAP - EC.02.06.01/EP13	Standard
§482.41(b)(1)(i)	A-0710	HAP - LS.02.01.20/EP29, LS.02.01.50/EP12	Standard

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.02.02.01

Standard Text: The hospital manages risks related to hazardous materials and waste.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

11. For managing hazardous materials and waste, the hospital has the permits, licenses, manifests, and material safety data sheets required by law and regulation. 

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 11
Observed in Environment of Care Session at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site.
There was no written documentation that the individual, that had signed the generator's certification on the uniform hazardous waste manifest for pharmaceutical waste, had received US Department of Transportation training for the safe packaging and transportation of hazardous materials.

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.02.03.01

Standard Text: The hospital manages fire risks.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

10. The written fire response plan describes the specific roles of staff and licensed independent practitioners at and away from a fire's point of origin, including when and how to sound fire alarms, how to contain smoke and fire, how to use a fire extinguisher, and how to evacuate to areas of refuge. (See also EC.02.03.03, EP 5; EC.03.01.01, EP 2; and HR.01.04.01, EP 2)
Note: For additional guidance, see NFPA 101, 2000 edition (Sections 18/19.7.1 and 18/19.7.2). 

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 10
Observed in Environment of Care Session at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site.
The written fire response plan did not describe how to use a fire extinguisher.

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.02.05.01

Standard Text: The hospital manages risks associated with its utility systems.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

4. The hospital identifies, in writing, the intervals for inspecting, testing, and maintaining all operating components of the utility systems on the inventory, based on criteria such as manufacturers' recommendations, risk levels, or hospital experience. (See also EC.02.05.05, EPs 3-5)

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 4
Observed in Environment of Care Session at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site.
There was documentation that the hospital had identified, in writing, the interval for inspecting, testing, and maintaining the air handling equipment for air exchange rates and air pressure relationships in those areas requiring specific air exchange rates and pressure relationships as annually. However, air exchange rates had not been verified since 2008.

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.02.05.07

Standard Text: The hospital inspects, tests, and maintains emergency power systems.
Note: This standard does not require hospitals to have the types of emergency power equipment discussed below. However, if these types of equipment exist within the building, then the following maintenance, testing, and inspection requirements apply.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

6. Twelve times a year, at intervals of not less than 20 days and not more than 40 days, the hospital tests all automatic transfer switches. The completion date of the tests is documented.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 6
§482.41(c)(2) - (A-0724) - (2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.
This Standard is NOT MET as evidenced by:
Observed in Document Review at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site for the Hospital deemed service.
There was no written documentation that the transfer switch, that serves the fire pump, had been tested monthly. It had not been part of the monthly generator load test. It did not appear on the list of automatic transfer switches on the monthly generator test form.

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.02.05.09

Standard Text: The hospital inspects, tests, and maintains medical gas and vacuum systems. Note: This standard does not require hospitals to have the medical gas and vacuum systems discussed below. However, if a hospital has these types of systems, then the following inspection, testing, and maintenance requirements apply.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

3. The hospital makes main supply valves and area shutoff valves for piped medical gas and vacuum systems accessible and clearly identifies what the valves control. 

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 3
Observed in Building Tour at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site.
The main supply valves for oxygen, nitrogen, nitrous oxide, and vacuum were not labeled to identify what the valves controlled. The valves were labeled during the survey.

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.02.06.01

Standard Text: The hospital establishes and maintains a safe, functional environment. Note: The environment is constructed, arranged, and maintained to foster patient safety, provide facilities for diagnosis and treatment, and provide for special services appropriate to the needs of the community.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

13. The hospital maintains ventilation, temperature, and humidity levels suitable for the care, treatment, and services provided. 

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 13
§482.41(c)(4) - (A-0726) - (4) There must be proper ventilation, light, and temperature controls in pharmaceutical, food preparation, and other appropriate areas.
This Standard is NOT MET as evidenced by:
Observed in Document Review at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site for the Hospital deemed service.
The 2008 ventilation study indicated that Delivery rooms one and two did not meet minimum air exchange rates. There was no documentation that the deficiency had been corrected.

Chapter: Life Safety

Program: Hospital Accreditation

Standard: LS.02.01.20

Standard Text: The hospital maintains the integrity of the means of egress.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

29. Stairs serving five or more stories have signs on each floor landing in the stairwell that identify the story, the stairwell, the top and bottom, and the direction to and story of exit discharge. The signs are placed 5 feet above the floor landing in a position that is easily visible when the door is open or closed. (For full text and any exceptions, refer to NFPA 101-2000: 7.2.2.5.4) 

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 29
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:
Observed in Building Tour at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site for the Hospital deemed service.
Signs on each floor landing, in the North stairwell, did not identify the top and bottom and the story of exit discharge.

Observed in Building Tour at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site for the Hospital deemed service.
Signs on each floor landing, in the South stairwell, did not identify the top and bottom and the story of exit discharge.

Observed in Building Tour at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site for the Hospital deemed service.
Signs on each floor landing, in the East stairwell, did not identify the top and bottom and the story of exit discharge.

Observed in Building Tour at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site for the Hospital deemed service.
Signs on each floor landing, in the West stairwell, did not identify the top and bottom and the story of exit discharge.

Chapter: Life Safety

Program: Hospital Accreditation

Standard: LS.02.01.50

Standard Text: The hospital provides and maintains building services to protect individuals from the hazards of fire and smoke.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

12. The hospital meets all other Life Safety Code building service requirements related to NFPA 101-2000: 18/19.5. 

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 12
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:
Observed in Document Review at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site for the Hospital deemed service.
There was no written documentation that all elevators equipped with fire fighter service had a monthly operation test, in February 2012, with a written record of the findings made and kept on the premises as required by NFPA 101-19.5.3 and NFPA 101 - 9.4.6.

Observed in Document Review at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site for the Hospital deemed service.
There was no written documentation that all elevators equipped with fire fighter service had a monthly operation test, in March 2012, with a written record of the findings made and kept on the premises as required by NFPA 101-19.5.3 and NFPA 101 - 9.4.6.

Observed in Document Review at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site for the Hospital deemed service.
There was no written documentation that all elevators equipped with fire fighter service had a monthly operation test, in April 2012, with a written record of the findings made and kept on the premises as required by NFPA 101-19.5.3 and NFPA 101 - 9.4.6.

Chapter: Medication Management
Program: Hospital Accreditation
Standard: MM.03.01.01
Standard Text: The hospital safely stores medications.
Primary Priority Focus Area: Medication Management

Element(s) of Performance:

3. The hospital stores all medications and biologicals, including controlled (scheduled) medications, in a secured area to prevent diversion, and locked when necessary, in accordance with law and regulation.
Note: Scheduled medications include those listed in Schedules II–V of the Comprehensive Drug Abuse Prevention and Control Act of 1970.

Scoring Category : A
Score : Insufficient Compliance

6. The hospital prevents unauthorized individuals from obtaining medications in accordance with its policy and law and regulation.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 3
§482.25(b)(2)(i) - (A-0502) - (2)(i) All drugs and biologicals must be kept in a secure area, and locked when appropriate.
This Standard is NOT MET as evidenced by:
Observed in Individual Tracer at Summit Outpatient Center (3901 Central Pike, Hermitage, TN) site for the Hospital deemed service.
Oral contrast (Readi-Cat) was stored in an unlocked refrigerator in the control area of the CT and MRI suite. On the weekends when the area was closed, the temperature of the refrigerator was not monitored to ensure that the contrast was stored according to manufacturer's recommendations. During the survey a lock was put on the refrigerator.

EP 6
§482.25(b)(2)(i) - (A-0502) - (2)(i) All drugs and biologicals must be kept in a secure area, and locked when appropriate.
This Standard is NOT MET as evidenced by:
Observed in Tracer Activities at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site for the Hospital deemed service.
The hospital's policy for the disposal of used duragesic patches required that the disposal be witnessed and documented by a second nurse. However, the patches were disposed of in a 16 gallon sharps container with an opening that would allow someone to reach in and remove the patch. The sharps containers were located in the soiled utility room that was locked, but accessible to other personnel including non-licensed personnel. The documentation of the disposal by two nurses was done in the pyxis machine located in another room on the unit. This method of disposal increased the potential risk of diversion after the patch was discarded.

Chapter: Medication Management
Program: Hospital Accreditation
Standard: MM.04.01.01
Standard Text: Medication orders are clear and accurate.
Primary Priority Focus Area: Medication Management

Element(s) of Performance:

13. The hospital implements its policies for medication orders. 

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 13
§482.23(c)(2) - (A-0406) - (2) With the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved hospital policy after an assessment of contraindications, orders for drugs and biologicals must be documented and signed by a practitioner who is authorized to write orders by hospital policy and in accordance with State law, and who is responsible for the care of the patient as specified under §482.12(c).
This Standard is NOT MET as evidenced by:
Observed in Individual Tracer at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site for the Hospital deemed service.
An order was written for a propofol sedation drip for a 78 year old patient who was placed on a ventilator. The order did not include the RASS goal for the sedation as required by hospital policy.

Observed in Individual Tracer at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site for the Hospital deemed service.
A 52 year old male admitted with diabetes received two units of Humalog insulin and there was no documentation in the record that the medication was double checked by a second RN as required by hospital policy.

Observed in Medication Management Tracer at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site.
During a high risk drug tracer, a patient was noted to have heparin protocol orders to increase the heparin drip if the PTT decreased to less than 46. The patient's PTT decreased to 38 on 5/20/2012 and heparin drip was not adjusted as required by protocol.

Chapter: Medication Management

Program: Hospital Accreditation

Standard: MM.05.01.01

Standard Text: A pharmacist reviews the appropriateness of all medication orders for medications to be dispensed in the hospital.

Primary Priority Focus Area: Medication Management

Element(s) of Performance:

8. All medication orders are reviewed for the following: Therapeutic duplication. 

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 8
Observed in Individual Tracer at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site.
On a post c/section patient the anesthesiologist ordered on a preprinted order sheet three prn medications for nausea: Zofran, Reglan, and a Scopolamine patch. The order did not specify which medication to give for a specific circumstance. It was not clear as to which medication(s) the nurse should give or in which order.

Observed in Individual Tracer at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site.
A second patient on 5th Surgical Floor was noted to have prn orders for both Zofran and Reglan for post-operative nausea with no indication of which drug to give or whether to give both drugs simultaneously. The orders were not clarified for therapeutic duplication.

Chapter: National Patient Safety Goals

Program: Hospital Accreditation

Standard: NPSG.03.04.01

Standard Text: Label all medications, medication containers, and other solutions on and off the sterile field in perioperative and other procedural settings.
Note: Medication containers include syringes, medicine cups, and basins.

Primary Priority Focus Area: Medication Management

Element(s) of Performance:

2. In perioperative and other procedural settings both on and off the sterile field, labeling occurs when any medication or solution is transferred from the original packaging to another container. 

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 2
Observed in Medication Management Tracer at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site.
During the Medication Management Tracer in the pharmacy, seven unlabeled syringes containing medications were noted to be unattended under the hood used for the preparation of TPN. Each syringe was carefully lined up next to a vial of medication. The medications were not labeled when they were drawn-up as required by regulation.

Chapter: Record of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: RC.01.01.01

Standard Text: The hospital maintains complete and accurate medical records for each individual patient.

Primary Priority Focus Area: Information Management

Element(s) of Performance:

19. For hospitals that use Joint Commission accreditation for deemed status purposes: All entries in the medical record, including all orders, are timed. 

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 19
§482.24(c)(1) - (A-0450) - (1) All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures.
This Standard is NOT MET as evidenced by:
Observed in Individual Tracer at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site for the Hospital deemed service.
A progress note written on a 56 year old patient admitted with fluid overload, shortness of breath and hypertension was not dated or timed by the physician as required by hospital policy.

Observed in Individual Tracer at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site for the Hospital deemed service.
A telephone order was authenticated without a date and time as required by CMS on a 56 year old male patient.

Observed in Individual Tracer at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site for the Hospital deemed service.
The immediate post procedure note for a 78 year old patient who had a incision and drainage of an infected finger was not timed as required by hospital policy.

Observed in Individual Tracer at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site for the Hospital deemed service.
The post procedure note for the placement of a vascatheter for dialysis access was not timed as required by hospital policy.

Observed in Individual Tracer at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site for the Hospital deemed service.
Several entries, eg treatment plan, initial evaluation, in the outpatient rehab charts were not timed as required by the hospital policy.

Observed in Individual Tracer at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site for the Hospital deemed service.
Medication reconciliation orders were not dated or timed by the ordering physician on an obstetrical patient.

Chapter: Rights and Responsibilities of the Individual

Program: Hospital Accreditation

Standard: RI.01.03.01

Standard Text: The hospital honors the patient's right to give or withhold informed consent.

Primary Priority Focus Area: Rights & Ethics

Element(s) of Performance:

5. The hospital's written policy describes how informed consent is documented in the patient record.
Note: Documentation may be recorded in a form, in progress notes, or elsewhere in the record.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 5
§482.24(c)(2)(v) - (A-0466) - [All records must document the following, as appropriate:]

(v) Properly executed informed consent forms for procedures and treatments specified by the medical staff, or by Federal or State law if applicable, to require written patient consent.
This Standard is NOT MET as evidenced by:
Observed in Individual Tracer at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site for the Hospital deemed service.
Hospital Informed Consent/Consent for Treatment policy does not describe how informed consent is documented in the medical record.

Patient-Centered Communication Standards

The Joint Commission recognizes that hospitals may require additional time to meet the requirements of the new and revised patient-centered communication standards. As such, the Joint Commission is providing a free monograph, Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered care: A Roadmap for Hospitals, on its website, jointcommission.org/patientsafety/hlc to inspire hospitals to integrate concepts from the communication, cultural competence, and patient- and family-centered care fields into their organizations. Throughout 2011, although surveyors will evaluate compliance with these requirements, they will not generate a requirement for improvement and/or affect an organization's accreditation decision.

Chapter: Provision of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: PC.02.01.21

Standard Text: The hospital effectively communicates with patients when providing care, treatment, and services.
Note: This standard will not affect the accreditation decision at this time.

Primary Priority Focus Area: Information Management

Element(s) of Performance:

1. The hospital identifies the patient's oral and written communication needs, including the patient's preferred language for discussing health care. (See also RC.02.01.01, EP 1) 

Note 1: Examples of communication needs include the need for personal devices such as hearing aids or glasses, language interpreters, communication boards, and translated or plain language materials.
Note 2: This element of performance will not affect the accreditation decision at this time.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 1
Observed in Individual Tracer at Summit Medical Center (5655 Frist Blvd., Hermitage, TN) site.
The hospital documents the patient's primary language rather than the patient's preferred language for receiving or discussing health care information.

P: Colleen Patterson
cc: Tom Oglburn

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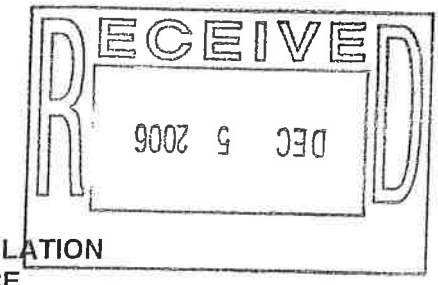

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
BUREAU OF HEALTH LICENSURE AND REGULATION
MIDDLE TENNESSEE REGIONAL OFFICE
710 HART LANE, 1ST FLOOR
NASHVILLE, TENNESSEE 37247-0530
PHONE (615) 650-7100
FAX (615) 650-7101

December 1, 2006

Jeffrey Whitehorn, Administrator
Summit Medical Center
5655 Frist Blvd
Hermitage, TN 37076

Dear Mr. Whitehorn:

Enclosed is the statement of deficiencies developed as the result of the revisit on the state licensure survey of Summit Medical Center on November 30, 2006.

Please provide us with documentation to describe how and when these deficiencies will be corrected. This information should be received in our office within ten (10) calendar days after receipt of this letter. It is imperative that you assure correction of the cited deficiencies no later than sixty (60) days from the date of the initial survey. A follow-up visit may be conducted, if your allegation of correction is reasonable and convincing. Failure to provide an acceptable plan of correction could result in a referral to the Board of Licensing Health Care Facilities for whatever action they deem appropriate.

In order for your Plan of Correction (PoC) to be acceptable, it should address the following:

1. How you will correct the deficiency;
2. Who will be responsible for correcting the deficiency;
3. The date the deficiency will be corrected; and
4. How you will prevent the same deficiency from happening again.

Should you have any questions, or if there is any way this office may be of assistance, please do not hesitate to call.

Sincerely,

Nina Monroe

Nina Monroe, Regional Administrator
Middle Tennessee Regional Office

ENCLOSURE

NM/dv

Summit Medical Center

TRISTAR HEALTH SYSTEM

December 11, 2006

ATTN: Nina Monroe, Regional Administrator
State of Tennessee
Department of Health
Bureau of Health Licensure and Regulation
Middle Tennessee Regional Office
710 Hart Lane, 1st Floor
Nashville, TN 37247-0530

Dear Ms. Monroe:

Attached you will find our responses to the Statement of Deficiencies resulting from your State Licensure Survey of Summit Medical Center on November 30, 2006.

Please note that we are requesting a "Desk Review" of items noted on Statement of Deficiencies form. I have attached documentation and code references highlighted with pertinent information to assist with this review.

If there are any questions, please contact me at 615-316-3645.

Sincerely,

Ted Jones
Director of Operations and Facilities

TJ/ds

Cc: Tom Ozburn, COO
Colleen Patterson, Director of Quality Management

PRINTED: 12/01/2006
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP53133	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	R 11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT MEDICAL CENTER	5655 FRIST BLVD HERMITAGE, TN 37076

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{H 901}	1200-8-1-.09 (1) Life Safety (1) Any hospital which complies with the required applicable building and fire safety regulations at the time the board adopts new codes or regulations will, so long as such compliance is maintained (either with or without waivers of specific provisions), be considered to be in compliance with the requirements of the new codes or regulations. This Statute is not met as evidenced by: Surveyor: 13846 Based on observation and inspection, it was determined the facility failed to comply with the life safety codes and the electrical codes. The findings included: On 11/30/06 at approximately 11:00 AM, inspection of the facility revealed the vent covers were dirty on the ground, first, second, third, fourth, fifth, sixth, and seventh floors revealed the vent covers were dirty. NFPA 01, 19.5.2.1 Inspection of the seventh floor biohazard room and the sixth floor soiled utility room revealed the electrical panels were blocked with equipment. NFPA 70, 110-26(a) Inspection of the imaging staff work room, and the men's dressing room by x-ray revealed cylinders of oxygen stored and no precautionary signs posted. NFPA 99. 9.6.3.2.1 Inspection of the corridors revealed cylinders of oxygen stored and no precautionary signs posted. NFPA 99, 9.6.3.2.1 Inspection of the lab office and the accounting	{H 901}	SEMI-ANNUAL VENT COVERS CLEANING PM TO START IMMEDIATELY AND COMPLETE BY END OF JANUARY. A RAIL TO PROVIDE PROPER CLEARANCES TO BE INSTALLED TO PREVENT ITEMS FROM BLOCKING PANELS. REQUEST "DESK REVIEW" OF THIS FINDING. REQUEST "DESK REVIEW" OF THIS FINDING.	1/30/2007 1/19/2007

PRINTED: 12/01/2006
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP53133	A. BUILDING 01 - MAIN BUILDING 01 B. WING	R 11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT MEDICAL CENTER	5655 FRIST BLVD HERMITAGE, TN 37076

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PRINTED: 12/01/2006
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Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP53133	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	R 11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT MEDICAL CENTER	5655 FRIST BLVD HERMITAGE, TN 37076

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{H 901}	Continued From page 1 office on the ground floor revealed power strips connected in tandem. NFPA 70, 373-4	{H 901}	THE POWER STRIP IN TANDEM WILL BE REMOVED SEE NOTE BELOW.	1/19/2007
	Inspection of the patient rooms second, third, fourth, fifth, sixth, and the seventh floors revealed the doors are not constructed to resist the passage of smoke. NFPA 101, 19.3.6.2		REQUEST "DESK REVIEW" OF THIS FINDING.	
	Inspection of the first and third floor smoking areas revealed no covered ashtrays. NFPA 101, 19.7.4(4)		METAL CONTAINERS WITH SELF-CLOSING COVERS ARE BEING ORDERED TO COMPLY WITH NFPA 19.7.4(6)	1/19/2007
			NOTE: STAFF HAS BEEN INSTRUCTED ON PROPER USE OF POWER STRIPS.	

9.5.3.1.2 Use. Carts and hand trucks that are intended to be used in anesthetizing locations or cylinder and container storage rooms communicating with anesthetizing locations shall comply with the appropriate provisions of 13.4.1.

9.5.3.2 Gas Equipment — Laboratory. Gas appliances shall be of an approved design and installed in accordance with NFPA 54, *National Fuel Gas Code*. Shutoff valves shall be legibly marked to identify the material they control.

9.6 Administration.

9.6.1 Policies.

9.6.1.1 Elimination of Sources of Ignition.

9.6.1.1.1 Smoking materials (e.g., matches, cigarettes, lighters, lighter fluid, tobacco in any form) shall be removed from patients receiving respiratory therapy.

9.6.1.1.2* No sources of open flame, including candles, shall be permitted in the area of administration.

9.6.1.1.3* Sparking toys shall not be permitted in any patient care area.

9.6.1.1.4 Nonmedical appliances that have hot surfaces or sparking mechanisms shall not be permitted within oxygen delivery equipment or within the site of intentional expulsion.

9.6.1.2 Misuse of Flammable Substances.

9.6.1.2.1 Flammable or combustible aerosols or vapors, such as alcohol, shall not be administered in oxygen-enriched atmospheres *(see B.6.1.11)*.

9.6.1.2.2 Oil, grease, or other flammable substances shall not be used on/in oxygen equipment.

9.6.1.2.3 Flammable and combustible liquids shall not be permitted within the site of intentional expulsion.

9.6.1.3 Servicing and Maintenance of Equipment.

9.6.1.3.1 Defective equipment shall be immediately removed from service.

9.6.1.3.2 Defective electrical apparatus shall not be used.

9.6.1.3.3 Areas designated for the servicing of oxygen equipment shall be clean, free of oil and grease, and not used for the repair of other equipment.

9.6.1.3.4 Service manuals, instructions, and procedures provided by the manufacturer shall be used in the maintenance of equipment.

9.6.1.3.5 A scheduled preventive maintenance program shall be followed.

9.6.2 Gases in Cylinders and Liquefied Gases in Containers.

9.6.2.1 Transfilling Cylinders.

(A) Mixing of compressed gases in cylinders shall be prohibited.

(B) Transfer of gaseous oxygen from one cylinder to another shall be in accordance with CGA Pamphlet P-2.5, *Transfilling of High-Pressure Gaseous Oxygen to Be Used for Respiration*.

(C) Transfer of any gases from one cylinder to another in patient care areas of health care facilities shall be prohibited.

9.6.2.2 Transferring Liquid Oxygen. Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows:

(1) The area is separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hr fire-resistive construction.
(2) The area is mechanically ventilated, is sprinklered, and has ceramic or concrete flooring.
(3) The area is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted.

9.6.2.2.1 Transferring shall be accomplished utilizing equipment designed to comply with the performance requirements and producers of CGA Pamphlet P-2.6, *Transfilling of Low-Pressure Liquid Oxygen to be Used for Respiration*, and adhering to those procedures.

9.6.2.2.2 The use and operation of small portable liquid oxygen systems shall comply with the requirements of CGA Pamphlet P-2.7, *Guide for the Safe Storage, Handling and Use of Portable Liquid Oxygen Systems in Health Care Facilities*.

9.6.2.3 Ambulatory Patients. Ambulatory patients on oxygen therapy shall be permitted access to all flame and smoke free areas within the health care facility.

9.6.3 Use (Including Information and Warning Signs).

9.6.3.1 Labeling.

9.6.3.1.1 Equipment listed for use in oxygen-enriched atmospheres shall be so labeled.

9.6.3.1.2 Oxygen-metering equipment and pressure-reducing regulators shall be conspicuously labeled:

OXYGEN — USE NO OIL

9.6.3.1.3 Flowmeters, pressure-reducing regulators, and oxygen-dispensing apparatus shall be clearly and permanently labeled, designating the gas or mixture of gases for which they are intended.

9.6.3.1.4 Apparatus whose calibration or function is dependent on gas density shall be labeled as to the proper supply gas gage pressure (psi/kPa) for which it is intended.

9.6.3.1.5 Oxygen-metering equipment, pressure-reducing regulators, humidifiers, and nebulizers shall be labeled with the name of the manufacturer or supplier.

9.6.3.1.6 Cylinders and containers shall be labeled in accordance with ANSI/CGA C-7, *Guide to the Preparation for Cautionary Labeling and Marking for Compressed Gas Containers*. Color coding shall not be utilized as a primary method of determining cylinder or container content.

9.6.3.1.7 All labeling shall be durable and withstand cleansing or disinfection.

9.6.3.2* Signs.

9.6.3.2.1 In health care facilities where smoking is not prohibited, precautionary signs readable from a distance of 1.5 m (5 ft) shall be conspicuously displayed wherever supplemental oxygen is in use and in aisles and walkways leading to that area; they shall be attached to adjacent doorways or to building walls or be supported by other appropriate means.

9.6.3.2.2 In health care facilities where smoking is prohibited and signs are prominently (strategically) placed at all major entrances, secondary signs with no-smoking language shall not be required.

9.6.3.2.3 The nonsmoking policies shall be strictly enforced.

Summit Medical Center
TRISTAR HEALTH SYSTEM

MANUAL: Environment of Care	**POLICY DESCRIPTION:** Smoking
PAGE: 1 of 2	**REPLACES POLICY DATED:** N/A
APPENDICES: N/A	**REVIEWED:** June 2006
EFFECTIVE DATE: February 1998	**SECTION NUMBER:** 1

PURPOSE:

To promote good health habits and provide a clean air environment for patients, visitors, employees, volunteers, and the medical staff.

POLICY:

There will be no smoking allowed in the interior of Summit Medical Center, its adjacent office buildings or Medical Center-owned vehicles by employees, visitors, patients or the medical staff.

PROCEDURE:

1. Patients
   A. Patients being admitted to Summit Medical Center will not be allowed to smoke in the interior of Summit Medical Center, its adjacent office buildings or Medical Center owned vehicles. Patients who must smoke must do so in the designated areas established in Section 4.

   B. Patients admitted to the Psychiatric Unit are permitted to smoke, on the smoking porch only when in the opinion of the psychiatrist failure to do so would adversely affect the effectiveness of therapeutic interventions and/or the therapeutic milieu of the patient. A physician's order is required.

   C. If a patient refuses to follow this policy, the patient will be reminded of the policy and it will be documented in the patient's chart in the progress notes. If the patient continues to be non-compliant, the physician will be notified and security will be contacted to witness the removal of smoking materials. Smoking materials will be returned to the patient at discharge.

2. Visitors
   A. Visitors will be allowed to smoke only in designated areas exterior to the hospital.

   B. If a visitor is found to be smoking in the interior of the Medical Center, he/she will be informed of Summit Medical Center's smoking policy, politely asked not to smoke inside the building, and directed to the nearest designated area.

   C. If a visitor refuses to cooperate, report the incident to Security for resolution.

3. Employees, Volunteers, Physicians and MOB Staff
   A. Employees, volunteers, physicians, and MOB staff will be allowed to smoke only in designated smoking areas outside the facility.

MANUAL: Environment of Care	POLICY DESCRIPTION: Smoking
PAGE: 2 of 2	

B. Any employee found to be smoking in the interior of the hospital or a non-designated area will be subject to disciplinary action up to and including termination.

C. Employees should be reminded that they are allowed a thirty minute lunch break. This break may be taken as a time to smoke in the designated areas outside the building, if so chosen by the employee.

4. Designated Smoking areas exterior to the Hospital and Medical Office Buildings
   A. Employees, physicians, and volunteers will be allowed to smoke in the courtyard by the employee entrance and the designated smoking area adjacent to the rear Imaging entrance for employees.

   B. Patients and visitors will be allowed to smoke at designated areas outside the rear Imaging Entrance, the Visitor and Patient entrance and the Same Day Surgery patio on First Floor.

   C. Ambulatory Surgery Center designated smoking area is adjacent to the receiving area.

APPROVALS:

A.19.3.5.4 The provisions of 19.3.5.4(6) and 19.3.5.4(7) are not intended to supplant NFPA 13, *Standard for the Installation of Sprinkler Systems*, which requires that residential sprinklers with more than a 5.6°C (10°F) difference in temperature rating not be mixed within a room. Currently there are no additional prohibitions in NFPA 13 on the mixing of sprinklers having different thermal response characteristics. Conversely, there are no design parameters to make practical the mixing of residential and other types of sprinklers.

A.19.3.5.6 For the proper operation of sprinkler systems, cubicle curtains and sprinkler locations need to be coordinated. Improperly designed systems might obstruct the sprinkler spray from reaching the fire or might shield the heat from the sprinkler. Many options are available to the designer including, but not limited to, hanging the cubicle curtains 46 cm (18 in.) below the sprinkler deflector; using 1.3-cm (½-in.) diagonal mesh or a 70 percent open weave top panel that extends 46 cm (18 in.) below the sprinkler deflector; or designing the system to have a horizontal and minimum vertical distance that meets the requirements of NFPA 13, *Standard for the Installation of Sprinkler Systems* The test data that forms the basis of the NFPA 13 requirements is from fire tests with sprinkler discharge that penetrated a single privacy curtain.

A.19.3.6.1(3) A typical nurses' station would normally contain one or more of the following with associated furniture and furnishings:

(1) Charting area
(2) Clerical area
(3) Nourishment station
(4) Storage of small amounts of medications, medical equipment and supplies, clerical supplies, and linens
(5) Patient monitoring and communication equipment

A.19.3.6.1(6)(b) A fully developed fire (flashover) occurs if the rate of heat release of the burning materials exceeds the capability of the space to absorb or vent that heat. The ability of common lining (wall, ceiling, and floor) materials to absorb heat is approximately 0.07 kJ per m^2 (0.75 Btu per ft^2) of lining. The venting capability of open doors or windows is in excess of 1.95 kJ per m^2 (20 Btu per ft^2) of opening. In a fire that has not reached flashover conditions, fire will spread from one furniture item to another only if the burning item is close to another furniture item. For example, if individual furniture items have heat release rates of 525 kW per second (500 Btu per second) and are separated by 305 mm (12 in.) or more, the fire is not expected to spread from item to item, and flashover is unlikely to occur. *(See also the NFPA Fire Protection Handbook.)*

A.19.3.6.1(7) This provision permits waiting areas to be located across the corridor from each other, provided that neither area exceeds the 55.7-m^2 (600-ft^2) limitation.

A.19.3.6.2.2 The intent of the ½-hour fire resistance rating for corridor partitions is to require a nominal fire rating, particularly where the fire rating of existing partitions cannot be documented. Examples of acceptable partition assemblies would include, but are not limited to 1.3-cm (½-in.) gypsum board, wood lath and plaster, gypsum lath, or metal lath and plaster.

A.19.3.6.2.3 An architectural, exposed, suspended-grid acoustical tile ceiling with penetrating items such as sprinkler piping and sprinklers; ducted HVAC supply and return-air diffusers; speakers; and recessed lighting fixtures is capable of limiting the transfer of smoke.

A.19.3.6.2.5 Monolithic ceilings are continuous horizontal membranes composed of noncombustible or limited-combustible materials, such as plaster or gypsum board, with seams or cracks permanently sealed.

A.19.3.6.2.6 The purpose of extending a corridor wall above a lay-in ceiling or through a concealed space is to provide a barrier to limit the passage of smoke. The intent of 19.3.6.2.6 is not to require light-tight barriers above lay-in ceilings or to require an absolute seal of the room from the corridor. Small holes, penetrations or gaps around items such as ductwork, conduit, or telecommunication lines should not affect the ability of this barrier to limit the passage of smoke.

A.19.3.6.3.1 Gasketing of doors should not be necessary to achieve resistance to the passage of smoke if the door is relatively tight-fitting.

A.19.3.6.3.5 While it is recognized that closed doors serve to maintain tenable conditions in a corridor and adjacent patient rooms, such doors, which under normal or fire conditions are self-closing, might create a special hazard for the personal safety of a room occupant. These closed doors might present a problem of delay in discovery, confining fire products beyond tenable conditions.

Because it is critical for responding staff members to be able to immediately identify the specific room involved, it is suggested that approved automatic smoke detection that is interconnected with the building fire alarm be considered for rooms having doors equipped with closing devices. Such detection is permitted to be located at any approved point within the room. When activated, the detector is required to provide a warning that indicates the specific room of involvement by activation of a fire alarm annunciator, nurse call system, or any other device acceptable to the authority having jurisdiction.

In existing buildings, use of the following options reasonably ensures that patient room doors will be closed and remain closed during a fire:

(1) Doors should have positive latches and a suitable program that trains staff to close the doors in an emergency should be established.
(2) It is the intent of the *Code* that no new installations of roller latches be permitted; however, repair or replacement of roller latches is not considered a new installation.
(3) Doors protecting openings to patient sleeping or treatment rooms, or spaces having a similar combustible loading might be held closed using a closer exerting a closing force of not less than 22 N (5 lbf) on the door latch stile.

A.19.3.6.3.8 Doors should not be blocked open by furniture, door stops, chocks, tie-backs, drop-down or plunger-type devices, or other devices that necessitate manual unlatching or releasing action to close. Examples of hold-open devices that release when the door is pushed or pulled are friction catches or magnetic catches.

A.19.3.6.3.10 It is not the intent of 19.3.6.3.10 to prohibit the application of push-plates, hardware, or other attachments on corridor doors in health care occupancies.

A.19.3.7.3(2) Where the smoke control system design requires dampers in order that the system functions effectively, it is not the intent of the exception to permit the damper to be omitted.

This provision is not intended to prevent the use of plenum returns where ducting is used to return air from a ceiling plenum through smoke barrier walls. Short stubs or jumper ducts

(3) If, in the opinion of the authority having jurisdiction, special hazards are present, a lock on the enclosure specified in 19.5.2.3(3) and other safety precautions shall be permitted to be required.

19.5.3 Elevators, Escalators, and Conveyors. Elevators, escalators, and conveyors shall comply with the provisions of Section 9.4.

19.5.4 Rubbish Chutes, Incinerators, and Laundry Chutes.

19.5.4.1 Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire-resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1 hour. All new chutes shall comply with Section 9.5.

19.5.4.2 Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with Section 9.7. *(See Section 9.5.)*

19.5.4.3 Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with Section 8.7.

19.5.4.4 Existing flue-fed incinerators shall be sealed by fire-resistive construction to prevent further use.

19.6 Reserved.

19.7* Operating Features.

19.7.1 Evacuation and Relocation Plan and Fire Drills.

19.7.1.1 The administration of every health care occupancy shall have, in effect and available to all supervisory personnel, written copies of a plan for the protection of all persons in the event of fire, for their evacuation to areas of refuge, and for their evacuation from the building when necessary.

19.7.1.2 All employees shall be periodically instructed and kept informed with respect to their duties under the plan required by 19.7.1.1.

19.7.1.3 A copy of the plan required by 19.7.1.1 shall be readily available at all times in the telephone operator's location or at the security center.

19.7.1.4* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions.

19.7.1.5 Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building.

19.7.1.6 Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions.

19.7.1.7 When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms.

19.7.1.8 Employees of health care occupancies shall be instructed in life safety procedures and devices.

19.7.2 Procedure in Case of Fire.

19.7.2.1* Protection of Patients.

19.7.2.1.1 For health care occupancies, the proper protection of patients shall require the prompt and effective response of health care personnel.

19.7.2.1.2 The basic response required of staff shall include the following:

(1) Removal of all occupants directly involved with the fire emergency
(2) Transmission of an appropriate fire alarm signal to warn other building occupants and summon staff
(3) Confinement of the effects of the fire by closing doors to isolate the fire area
(4) Relocation of patients as detailed in the health care occupancy's fire safety plan

19.7.2.2 Fire Safety Plan. A written health care occupancy fire safety plan shall provide for the following:

(1) Use of alarms
(2) Transmission of alarm to fire department
(3) Emergency phone call to fire department
(4) Response to alarms
(5) Isolation of fire
(6) Evacuation of immediate area
(7) Evacuation of smoke compartment
(8) Preparation of floors and building for evacuation
(9) Extinguishment of fire

19.7.2.3 Staff Response.

19.7.2.3.1 All health care occupancy personnel shall be instructed in the use of and response to fire alarms.

19.7.2.3.2 All health care occupancy personnel shall be instructed in the use of the code phrase to ensure transmission of an alarm under the following conditions:

(1) When the individual who discovers a fire must immediately go to the aid of an endangered person
(2) During a malfunction of the building fire alarm system

19.7.2.3.3 Personnel hearing the code announced shall first activate the building fire alarm using the nearest manual fire alarm box, then shall execute immediately their duties as outlined in the fire safety plan.

19.7.3 Maintenance of Exits.

19.7.3.1 Proper maintenance shall be provided to ensure the dependability of the method of evacuation selected.

19.7.3.2 Health care occupancies that find it necessary to lock exits shall, at all times, maintain an adequate staff qualified to release locks and direct occupants from the immediate danger area to a place of safety in case of fire or other emergency.

19.7.4* Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions:

(1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking.
(2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required.
(3) Smoking by patients classified as not responsible shall be prohibited.
(4) The requirement of 19.7.4(3) shall not apply where the patient is under direct supervision.

(5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.
(6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.

19.7.5 Furnishings, Bedding, and Decorations.

19.7.5.1* Draperies, curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies shall be in accordance with the provisions of 10.3.1 *(see 19.3.5.6)*, and the following also shall apply:

(1) Such curtains shall include cubicle curtains.
(2) Such curtains shall not include curtains at showers.

19.7.5.2 Newly introduced upholstered furniture within health care occupancies shall meet the criteria specified when tested in accordance with the methods cited in 10.3.2(2) and 10.3.3.

19.7.5.3 The requirement of 19.7.5.2 shall not apply to upholstered furniture belonging to the patient in sleeping rooms of nursing homes where the following criteria are met:

(1) A smoke detector shall be installed in such rooms.
(2) Battery-powered single-station smoke detectors shall be permitted.

19.7.5.4 Newly introduced mattresses within health care occupancies shall meet the criteria specified when tested in accordance with the methods cited in 10.3.2(3) and 10.3.4.

19.7.5.5 The requirement of 19.7.5.4 shall not apply to mattresses belonging to the patient in sleeping rooms of nursing homes where the following criteria are met:

(1) A smoke detector shall be installed in such rooms.
(2) Battery-powered, single-station smoke detectors shall be permitted.

19.7.5.6 Combustible decorations shall be prohibited in any health care occupancy unless one of the following criteria is met:

(1) They are flame-retardant.
(2) They are decorations such as photographs and paintings in such limited quantities that a hazard of fire development or spread is not present.

19.7.5.7 Soiled linen or trash collection receptacles shall not exceed 121 L (32 gal) in capacity, and the following also shall apply:

(1) The average density of container capacity in a room or space shall not exceed 20.4 L/m^2 (0.5 gal/ft^2).
(2) A capacity of 121 L (32 gal) shall not be exceeded within any 6-m^2 (64-ft^2) area.
(3) Mobile soiled linen or trash collection receptacles with capacities greater than 121 L (32 gal) shall be located in a room protected as a hazardous area when not attended.
(4) Container size and density shall not be limited in hazardous areas.

19.7.6 Maintenance and Testing. *(See 4.6.13.)*

19.7.7* Engineered Smoke Control Systems.

19.7.7.1 Existing engineered smoke control systems, unless specifically exempted by the authority having jurisdiction, shall be tested in accordance with established engineering principles.

19.7.7.2 Systems not meeting the performance requirements of such testing shall be continued in operation only with the specific approval of the authority having jurisdiction.

19.7.8 Portable Space-Heating Devices. Portable space-heating devices shall be prohibited in all health care occupancies, unless both of the following criteria are met:

(1) Such devices are used only in nonsleeping staff and employee areas.
(2) The heating elements of such devices do not exceed 100°C (212°F).

19.7.9 Construction, Repair, and Improvement Operations.

19.7.9.1 Construction, repair, and improvement operations shall comply with 4.6.11.

19.7.9.2 The means of egress in any area undergoing construction, repair, or improvements shall be inspected daily for compliance with of 7.1.10.1 and shall also comply with NFPA 241, *Standard for Safeguarding Construction, Alteration, and Demolition Operations.*

Chapter 20 New Ambulatory Health Care Occupancies

20.1 General Requirements.

20.1.1 Application.

20.1.1.1 General.

20.1.1.1.1 The requirements of this chapter shall apply to the following:

(1) New buildings or portions thereof used as ambulatory health care occupancies *(see 1.3.1)*
(2) Additions made to, or used as, an ambulatory health care occupancy *(see 4.6.7 and 20.1.1.4)*, unless all of the following criteria are met:
  (a) The addition is classified as an occupancy other than an ambulatory health care occupancy.
  (b) The addition is separated from the ambulatory health care occupancy in accordance with 20.1.2.2.
  (c) The addition conforms to the requirements for the specific occupancy.
(3) Alterations, modernizations, or renovations of existing ambulatory health care occupancies *(see 4.6.8 and 20.1.1.4)*
(4) Existing buildings or portions thereof upon change of occupancy to an ambulatory health care occupancy *(see 4.6.12)*

20.1.1.1.2 Ambulatory health care facilities shall comply with the provisions of Chapter 38 and this chapter, whichever is more stringent.

20.1.1.1.3 This chapter establishes life safety requirements, in addition to those required in Chapter 38, for the design of all ambulatory health care occupancies as defined in 3.3.152.1.

20.1.1.1.4 Buildings, or sections of buildings, that primarily house patients who, in the opinion of the governing body of the facility and the governmental agency having jurisdiction, are capable of exercising judgment and appropriate physical action for self-preservation under emergency conditions shall

Summit Medical Center

TRI STAR HEALTH SYSTEM

March 16, 2007

ATTN: Nina Monroe, Regional Administrator
State of Tennessee
Department of Health
Bureau of Health Licensure and Regulation
Middle Tennessee Regional Office
710 Hart Lane, 1st Floor
Nashville, TN 37247-0530

Dear Ms. Monroe:

Attached you will find our plan of correction to the Statement of Deficiencies resulting from your State Licensure Survey of Summit Medical Center on March 6, 2007.

If there are any questions, please contact me at 615-316-3645.

Sincerely,

Ted Jones
Director of Operations and Facilities

TJ/ds

Cc: Tom Ozburn, COO
Colleen Patterson, Director of Quality Management

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP53133	A. BUILDING 01 - MAIN BUILDING 01 B. WING	R 03/06/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT MEDICAL CENTER	5655 FRIST BLVD HERMITAGE, TN 37076

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{H 901}	1200-8-1-.09 (1) Life Safety (1) Any hospital which complies with the required applicable building and fire safety regulations at the time the board adopts new codes or regulations will, so long as such compliance is maintained (either with or without waivers of specific provisions), be considered to be in compliance with the requirements of the new codes or regulations. This Statute is not met as evidenced by: Surveyor: 13846 Based on observation and inspection, it was determined the facility failed to comply with the life safety codes. The findings included: On 3/02/07 at approximately 10:00 AM, inspection of the corridors revealed cylinders of oxygen stored and no precautionary signs posted. NFPA 99, 9.6.3.2.1 Inspection of the patient rooms on second, third, fourth, fifth, sixth, and seventh floors revealed the doors are not constructed to resist the passage of smoke. NFPA 101, 19.3.6.2	{H 901}	CONFERRED WITH BILL HARMON ON 3.6.07. WITH NO SMOKING SIGNAGE ON MAIN ENTRANCES FOR GENERAL PUBLIC HE FELT WE HAD MET INTENT OF NFPA 99. CRASH CARTS AND BEDS FOR TRANSPORTING PATIENTS WITH OXYGEN BOTTLES ARE NOT CONSIDERED STORED. UL LISTED SMOKE SEALS ARE BEING INSTALLED ON PATIENT ROOM DOORS.	4.20.07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Director of Facilities

TITLE

(X6) DATE: 3.15.07

SUPPLEMENTAL #1

SUPPLEMENTAL- # 1
February 21, 2014
3:50pm

DSG Development Support Group

February 21, 2014

Phillip M. Earhart, HSD Examiner
Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

RE: CON Application CN1402-004
TriStar Summit Medical Center

Dear Mr. Earhart:

This letter responds to your recent request for additional information on this application. The items below are numbered to correspond to your questions. They are provided in triplicate, with affidavit.

Filing Fee

1. The filing fee check from the applicant in the amount of $4,609.00 is noted. However, it appears the filing fee is $4,069, a difference of $540.00. Please note a refund of $540.00 will be requested on behalf of the applicant.

Thank you for noticing the transposition of digits. Summit will look forward to receiving the refund.

2. Section A, Applicant Profile, Item 3
Please provide a correct contact phone number for HCA Health Services of Tennessee, Inc. and submit a replacement page. The phone number provided is for Horizon Medical Center located in Dickson, Tennessee.

Please see revised page 1R, attached after this page. The revised phone number is for Summit Medical Center administration, which is the appropriate number for CON purposes.

3. Section A, Applicant Profile, Item 9
a. There appears to be a typo in the number of staffed beds for ICU/CCU. Please correct and submit a replacement page.

The correct number is 24 rather than 124 ICU beds. Also, Summit fully staffs its 24 OB beds. Revised page 3R is attached following this page, showing that all licensed beds are fully staffed.

4219 Hillsboro Road, Suite 203
Nashville, TN 37215
jwdsg@comcast.net
Tel 615.665.2022
Fax 615.665.2042

SUPPLEMENTAL- # 1
February 21, 2014
3:50pm

b. There appear to be four (4) unstaffed obstetrical beds. Please discuss the status and plan for these four (4) unstaffed beds. Are there any other unstaffed licensed beds?

These beds are currently being staffed. This was a typographical oversight. In addition, there are no other unstaffed licensed beds. A revised page 3R is attached preceding this page, in response to question 3b.

4. **Section A, Applicant Profile, Item 13**
The applicant's contractual relationships with AmeriGroup, United Community Healthcare Plan and TennCare Select are noted. However, new TennCare contracts will take effect January 1, 2015 with full statewide implementation for AmeriGroup, BlueCare Tennessee and United Healthcare. Please indicate if the applicant intends to contract with BlueCare Tennessee. If so, what stage of contract discussions is the applicant involved with BlueCare Tennessee?

Our intent is to be in-network with BlueCare Tennessee and negotiations are underway in order to be effective by January 1, 2015.

5. **Section B, Project Description, Item II A.**
The total construction cost of $1,161,143 in Table Two appears to be incorrect. Please revise.

Revised pages 11R and 38R (both of which contained Table Two) are attached following this page. These change the typographical error from $1,161,143 to $1,161,133 to agree with the narrative and elsewhere.

6. **Section B, Project Description, Item III.B.1**
The round trip mileage and drive times in table five is noted. However, there appears to be errors in the table. Please verify all calculations, and resubmit if necessary.

The hospital specific data is correct but the averages lines are not. Attached following this page is revised page 18R simplifying the table and correcting it. Also attached is revised page 16R which references average driving distances and times.

7. **Section B, Project Description, Item IV.**
The floor plan for the proposed project is noted. However, please include the floor plan for the 7th floor which will indicate the relation of the proposed project to nursing stations, ancillary services, etc. When providing the floor plan, please outline the location of the proposed project.

A floor plan of the entire floor is attached following this page.

8. **Need, Item 1. (Service Specific Criteria-Construction, Renovation, Expansion and replacement of Health Care Institutions)**
Please address the criteria for Construction, Renovation, Expansion and replacement of Health Care Institutions.

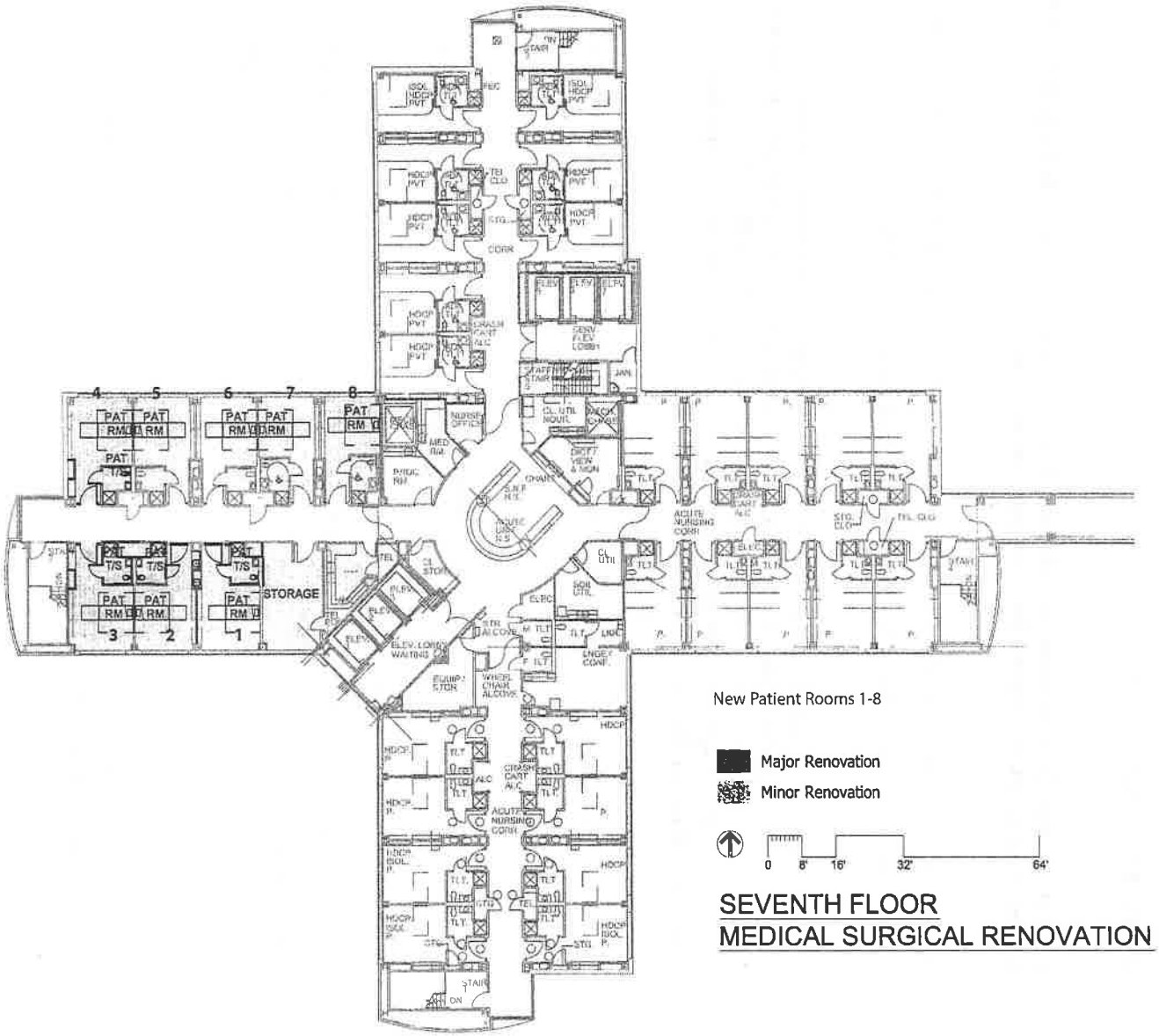
Responses are attached after this page, following Summit's seventh floor plan. The response page is numbered as page 23a-Supplemental.

9. **Need, Item 1. (Service Specific Criteria-Acute Care Bed Services, #1)**
a. Table six is noted on page 20. The table is labeled "minimal impact of two additional beds on services area hospital bed complements". Please clarify if the table should be for eight (8) beds instead.

Yes; that was a typographical error. Attached after this page, following the supplemental criteria referenced in question 8 above, is a revised page 20R.

b. Please indicate the 2012 licensed occupancy of inpatient medical surgical beds for each of the HCA hospitals in the applicant's service area.

Please see the attached utilization and occupancy table after this page, following page 20R.



New Patient Rooms 1-8

Major Renovation

Minor Renovation

0 8' 16' 32' 64'

SEVENTH FLOOR
MEDICAL SURGICAL RENOVATION

TriStar Summit Medical Center
Hermitage, TN

Seventh Floor | Proposed
MED SURG

GS&R

PROJECT No.
[illegible]3.00
January 6, 2014

[illegible] - #1
1, 2014
8:50pm

CN1402-004
Summit Medical Center--Addition of Eight Medical-Surgical Beds
Response to Supplemental Question #8

Project-Specific Review Criteria: Construction, Renovation, Expansion, and Replacement of Health Care Institutions

1. Any project that includes the addition of beds, services, or medical equipment will be reviewed under the standards for those specific activities.

The applicant has addressed the specific Guidelines for Growth review criteria for the addition of licensed hospital beds, immediately preceding this response.

2. For relocation or replacement of an existing licensed healthcare institution:
a. The applicant should provide plans which include costs for both renovation and relocation, demonstrating the strengths and weaknesses of each alternative.
b. The applicant should demonstrate that there is an acceptable existing or projected future demand for the proposed project.

Criteria 3a and 3b are not applicable. This project will not relocate or replace a licensed institution.

3. For renovation or expansion of an existing licensed healthcare institution:
a. The applicant should demonstrate that there is an acceptable existing demand for the proposed project.

In Section B.II.C above (Project Need) and in Table 10, page 32, the applicant presents data demonstrating that the proposed expanded medical-surgical bed complement will be utilized at and above 80% average occupancy during its first two years of operation, CY2015 and CY2016.

b. the applicant should demonstrate that the existing physical plant's condition warrants major renovation or expansion.

This criterion is not applicable because the expansion has nothing to do with the physical plant's condition.

Response to Supplemental Question 9(b) HCA Davidson County Hospitals Medical-Surgical Admissions & Occupancy in CY2013				
	Licensed Beds*	**Admissions**	**Patient Days**	**Occupancy %**
Centennial Medical Center	240	17,094	68,042	77.7%
Skyline Medical Center	134	8,361	34,583	70.7%
Southern Hills Medical Center	53	3,267	12,227	63.2%
Summit Medical Center	110	7,589	31,294	77.9%
Total	537	36,311	146,146	74.6%

Source: Hospital Management

**Medical-Surgical classified beds only*

c. On page 20 of the application, it is noted there is a surplus of 1,053 acute care hospital beds in the proposed service area. With this in mind, has the applicant considered de-licensing eight (8) inpatient med surgical beds at another HCA owned hospital in the service area so that eight (8) additional medical surgical beds are not added to a service area that already has a surplus of medical surgical beds? Please discuss.

De-licensing beds at another HCA facility is not a viable option. As shown in the previous chart, the average occupancy for all HCA facilities in Davidson County is 74.6%, with only one hospital (Southern Hills) being below 70% occupancy. De-licensing 8 beds from another HCA hospital does not allow for efficient occupancy of patients in their service area. Although the average occupancy is below 80%, it does not take into account peak occupancy times throughout the year.

10. **Section C, Need, Item 4.A.**
Table eight on page 28 of the demographic characteristics of the Primary service area counties is noted. However, please revise table eight using Tennessee Department of Health 2013 population statistics from the following web-site:
http://health.state.tn.us/statistics/pdffiles/CertNeed/Population_Projections_2010-20.pdf

In reviewing this table the applicant noted that its Statewide population data was not for 2014 and 2018, as were all other entries in this table. Attached following this page are revised pages 27R-28R correcting those entries.

The applicant has used TDH's September 2013 population projection series, which incorporates the 2010 U.S. Census findings and replaces the 2008 series formerly used for State purposes.

11. **Section C. Economic Feasibility Item 1 (Project Cost Chart) and Item 3**
The Architect's letter in the attachments is noted. However, please clarify the reason 4,406 SF of construction area at a cost of $1,161,133 is listed rather than 7,406 square feet.

Attached following this page is a revised letter that includes the MOB space.

SUPPLEMENTAL- # 1
February 21, 2014
3:50pm

GRESHAM
SMITH AND
PARTNERS

February 20, 2014

Mr. Jeff Whitehorn, CHE
Chief Executive Officer
Summit Medical Center
5655 Frist Boulevard
Hermitage, TN 37076

Subject: **Verification of Construction Cost Estimates**
7th Floor 8-Bed Med/Surg Unit
Summit Medical Center
Hermitage, Tennessee
GS&P Project No. 29963.00 / 0.1

Gresham, Smith and Partners, Inc., an architectural/engineering firm in Nashville, Tennessee, has reviewed the cost data provided by HCA for the above-referenced project, for which this firm has provided a preliminary design. The stated renovated construction cost for this 7,606 SF area is $1,161,133. [In providing options of probably construction cost, the Client understands that the Consultant has no control over the cost or availability of labor, equipment or materials, or over market conditions or the Contractor's method of pricing, and that the Consultant's options of probable construction costs are made on the basis of the Consultant's professional judgment and experience. The Consultant makes no warrant, express or implied, that the bids or the negotiated cost of the Work will not vary from the Consultant's opinion of probable construction cost.]

It is our opinion that at this time, the projected renovated construction cost is reasonable for this type and size of project and compares appropriately with similar projects in this market.

The building codes applicable to this project will be:

International Building Code, 2006
NFPA 101 Life Safety Code, 2006
FGI Guidelines for Design & Construction of Healthcare Facilities, 2010
ANSI-117.1, 2003

Sincerely,

Kenneth A. Priest, AIA, NCARB, LEED AP
License No. 16010

bma

12. Section C, Economic Feasibility, Item 5
Table Eleven consisting of Charges, Deductions, Net Charges and Net operating Income is noted. However, there appears to be a calculation error in the average gross charge per day for CY2017. Please revise.

In Year Two, two digits were transposed as a typographical error. Attached after this page is a revised page 44R changing $13,429 to $13,249.

13. Section C, Economic Feasibility, Item 6.B
The applicant refers to table thirteen. Please provide the referenced table.

Table Thirteen, Most Frequent Charges, is attached after this page, following revised page 44R. It is paginated as page 46a.

14. Section C, Economic Feasibility, Item 10
The applicant's financial documents are noted. Please clarify if the documents are audited.

The hospital's statements are not audited. HCA does not audit financial statements at the hospital level. HCA does audits on its consolidated financial statements.

15. Section C, Orderly Development, Item 7 (d)
The copy of the most recent licensure inspection dated March 6, 2007 is noted. Please clarify if there have been any licensure surveys or inspections since March 6, 2007 by the State of Tennessee. If so, please provide a copy.

Attached is an occupancy approval notice from Metro Nashville & Davidson County after inspecting recently completed construction on the third and fourth floors. However, there has not been a TDOH facility-wide inspection since the 2007 report.

Thank you for your assistance. We hope this provides the information needed to accept the application into the next review cycle. If more is needed please FAX or telephone me so that we can respond in time to be deemed complete.

Respectfully,

John Wellborn

John Wellborn
Consultant

KARL F. DEAN
MAYOR

METROPOLITAN GOVERNMENT OF NASHVILLE AND DAVIDSON COUNTY

DEPARTMENT OF CODES & BUILDING SAFETY

OFFICE ADDRESS
METRO OFFICE BUILDING – 3rd FLOOR
800 SECOND AVENUE, SOUTH
NASHVILLE, TENNESSEE 37210

MAILING ADDRESS
POST OFFICE BOX 196300
NASHVILLE, TENNESSEE 37219-6300
TELEPHONE (615) 862-6500
FACSIMILE (615) 862-6514
www.nashville.gov/codes

January 30, 2014

BATTEN & SHAW INC
107 MUSIC CITY CIRCLE, SUITE 300
NASHVILLE, TN 37214

RE: **FINAL USE AND OCCUPANCY**
5655 Frist Blvd, HERMITAGE, TN 37076
Map/Parcel No: 08600006400
Building Permit: 201225953
Issued: September 18, 2013

Gentlemen:

The Department of Codes and Building Safety and other required Metropolitan Departments have inspected the recent rehab in Third Floor patient rooms and nurse station at "Summit Medical Center" at the above location.

Through routine inspections and visual observations it has been determined that the work performed substantially complies with the applicable codes and ordinances of the Metropolitan Government of Nashville and Davidson County. Therefore, we hereby approve it for **Final Use and Occupancy**. However, granting of the **Final Use and Occupancy** in no way relieves the **contractors of their** responsibility for any work performed not in accordance with applicable codes and ordinances.

Thank you for your cooperation.

Very truly yours,

Barbara Shaw

Wade Hill
Assistant Director

WH: wbs

cc: Map/Parcel File

SUPPLEMENTAL- # 1
February 21, 2014
3:50pm

FEB 21 '14 03:45

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF DAVIDSON

NAME OF FACILITY: SUMMIT MEDICAL CENTER

I, JOHN WELLBORN, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

JAN M. DANFORTH
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY
My Commission Expires November 5, 2014

John Wellborn
Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 21ST day of Feb., 2014, witness my hand at office in the County of Davidson, State of Tennessee.

NOTARY PUBLIC

My commission expires November 5, 2014.

HF-0043

Revised 7/02

COPY-
SUPPLEMENTAL-2

TriStar Summit Medical ctr.

CN1402-004

DSG Development Support Group

SUPPLEMENTAL- # 2
February 27, 2014
8:00am

February 26. 2014

Phillip M. Earhart, HSD Examiner
Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

RE: CON Application CN1402-004
TriStar Summit Medical Center

Dear Mr. Earhart:

This letter responds to your second request for additional information on this application. The items below are numbered to correspond to your questions. They are provided in triplicate, with affidavit.

1. **Section B, Project Description, Item III.B.1**
The revised round trip mileage and drive times in table five is noted. However, there appears to be an error in the table for the mileage roundtrip calculation for Skyline Medical Center, Nashville. Please verify all calculations, and resubmit if necessary. Also, please update page 16R of the referenced roundtrip average.

All entries in Table Five and the statements on page 16R are correct, except for that single Table Five entry for Skyline's round trip mileage. It was mistyped when transferring the statistics from the Excel spreadsheet where the averages were calculated.

Attached after this page is revised page 18R-Second Supplemental, with that incorrect entry of 17.5 miles corrected to 33.6 miles. The Table Five average mileages, and the narrative on page 16R, were submitted correctly in the first supplemental response and do not need correction.

4219 Hillsboro Road, Suite 203
Nashville, TN 37215
jwdsg@comcast.net
Tel 615.665.2022
Fax 615.665.2042

B.III.B.1. DESCRIBE THE RELATIONSHIP OF THE SITE TO PUBLIC TRANSPORTATION ROUTES, IF ANY, AND TO ANY HIGHWAY OR MAJOR ROAD DEVELOPMENTS IN THE AREA. DESCRIBE THE ACCESSIBILITY OF THE PROPOSED SITE TO PATIENTS/CLIENTS.

Summit Medical Center is located in Hermitage, on the far eastern edge of Davidson County near the Wilson County line. The hospital is on the west side of Old Hickory Boulevard / Highway 45, approximately one mile north of Exit 221 from I-40, and is visible from that exit. Summit serves patients primarily from eastern Davidson County and western Wilson County. Interstate I-40 and U.S. Highway 70, which run east and west between Nashville and Lebanon, are the service area's principal east-west roadways; Old Hickory Boulevard is one of the service area's major roadways running north-south beside the Summit campus.

Summit is very accessible to western Wilson County, as well as to eastern Davidson County between Old Hickory Lake (the Cumberland River) and the areas west, north, and east of Percy Priest Lake. The rapidly growing Mt. Juliet community is the fastest growing sector of western Wilson County; and Mt. Juliet is much closer to Summit Medical Center (6.9 miles; 15 minutes) than it is to University Medical Hospital in Lebanon (13.2 miles; 19 minutes).

Table Five: Round-Trip Mileage and Drive Times Between Hermitage and Other Medical-Surgical Beds In the Primary Service Area

Location of Medical-Surgical Beds	Mileage 1-Way	Time 1-Way	Mileage Rd-Trip	Time Rd-Trip
Centennial Medical Center	13.6	19 min.	27.2	38 min.
Metro NV General Hospital	13.8	19 min.	27.6	38 min.
Saint Thomas Midtown Hospital	13.1	17 min.	26.2	34 min.
Saint Thomas West Hospital	16.8	21 min.	33.6	42 min.
Skyline Medical Center, Nashville	16.8	20 min.	33.6	40 min.
Southern Hills Medical Center	11.1	18 min.	22.2	36 min.
The Center for Spinal Surgery	13.3	18 min.	26.6	36 min
Vanderbilt Medical Center	13.4	18 min.	26.8	36 min.
University Medical Center (UMC)	21.5	24 min.	43.0	48 min
Averages	**14.8 mi.**	**19.3 min.**	**29.6 mi.**	**38.7 min.**

Source: Google Maps, January 2014. All facilities are in Davidson County, except UMC, which is in Lebanon, Wilson County.

Page Two
February 26, 2014

2. Need, Item 1. (Service Specific Criteria-Construction, Renovation, Expansion and replacement of Health Care Institutions) 3.a.

The applicant references table 10 on page 32 and states the proposed expanded medical-surgical bed complement will be utilized at and above 80% average occupancy during the first two years of occupancy. However, 23-hour observation beds should not be included in the occupancy calculations. Since 23 hour observation beds are not counted as medical-surgical beds, please exclude those beds and revise the total occupancy percentages for years 2011-2014, and Project Year One and Project Year Two. In addition, please revise your narrative response and submit a revised page 23R.

Table Ten provided two occupancy statistics: (a) occupancy based on licensed bed days for patients admitted with a status of "inpatient", and (b) occupancy based on licensed bed days for both patients admitted with a status "inpatient" and the status of "23-hour observation." Summit's observation patients are cared for in licensed medical-surgical beds and Summit does not have a dedicated observation unit. The table appears to need no amendment.

The page 15 bed use line graph and bed need narratives around that graph in Section B. II.C reflect licensed beds' actual occupancies by both inpatients and observation patients, depicting the actual daily census. It is Summit's case for adding capacity, and appears not to need any amendment.

3. Need, Item 1. (Service Specific Criteria-Acute Care Bed Services, #1)

a. The table of 2012 licensed occupancy of inpatient medical surgical beds for each of the HCA hospitals in the applicant's service area is noted. However, please clarify if the table includes 23 hour observation beds. If so, please provide a revised table minus 23 hour observation beds.

That supplemental table does not include observation beds or observation days. It included only HCA's licensed, operational medical-surgical beds.

b. The applicant states the de-licensing of eight (8) beds from another HCA hospital is not a viable option since the average occupancy of all HCA facilities in Davidson County is 74.5% and does not take into account peak times of the year. However, please explain the reason eight beds could not be de-licensed from Skyline Medical Center's Madison campus located in Davidson County. According to the 2012 Joint Annual Report, Skyline Madison is licensed for 172 beds, but only staffs 110 beds. The licensed occupancy in 2012 of Skyline Madison campus was 40.2%.

Of the 172 currently licensed beds at Skyline Madison, 121 are used for psychiatric/chemical dependency services and 16 by Alive Hospice for hospice services to the community--all of which are being utilized. The remaining 35 licensed beds have not been in service for several years, and are being held for future use by Skyline. HCA has previously de-licensed beds in other projects, but is not proposing to do so in this project.

c. Please also clarify if the 2013 average occupancy of 74.5% of all HCA facilities in Davidson County included the Skyline Madison campus.

It did not include Skyline Madison because Skyline Madison is now dedicated only to behavioral patient care, e.g., psychiatric and chemical dependency beds. The data submitted concerned utilization of HCA's general acute care facilities/campuses like Summit. The beds are HCA's operational, licensed, medical/surgical bed complements.

4. **Section C. Economic Feasibility Item 1 (Project Cost Chart) and Item 3**
The revised Architect's letter is noted. However, the referenced sq. ft. is 7,606, rather than 7,406 square feet as mentioned in the application. Please revise.

The requested revised letter is attached after this page.

5. **Section C, Economic Feasibility, Item 4**
The patient days in the Projected Data Chart of 476 in Year One and 646 in Year Two is noted. However, please clarify if the projected patient days include 23 hour observation beds. If so, please revise the projected data chart to not include 23 hour observation bed in the patient day calculation.

No observation admissions or days were included in the Projected Data Chart.

SUPPLEMENTAL- # 2
February 27, 2014
8:00am

GRESHAM
SMITH AND
PARTNERS

February 20, 2014

Mr. Jeff Whitehorn, CHE
Chief Executive Officer
Summit Medical Center
5655 Frist Boulevard
Hermitage, TN 37076

Subject: **Verification of Construction Cost Estimates**
7th Floor 8-Bed Med/Surg Unit
Summit Medical Center
Hermitage, Tennessee
GS&P Project No. 29963.00 / 0.1

Gresham, Smith and Partners, Inc., an architectural/engineering firm in Nashville, Tennessee, has reviewed the cost data provided by HCA for the above-referenced project, for which this firm has provided a preliminary design. The stated renovated construction cost for this 7,406 SF area is $1,161,133. [In providing options of probably construction cost, the Client understands that the Consultant has no control over the cost or availability of labor, equipment or materials, or over market conditions or the Contractor's method of pricing, and that the Consultant's options of probable construction costs are made on the basis of the Consultant's professional judgment and experience. The Consultant makes no warrant, express or implied, that the bids or the negotiated cost of the Work will not vary from the Consultant's opinion of probable construction cost.]

It is our opinion that at this time, the projected renovated construction cost is reasonable for this type and size of project and compares appropriately with similar projects in this market.

The building codes applicable to this project will be:

International Building Code, 2006
NFPA 101 Life Safety Code, 2006
FGI Guidelines for Design & Construction of Healthcare Facilities, 2010
ANSI-117.1, 2003

Sincerely,

Kenneth A. Priest, AIA, NCARB, LEED AP
License No. 16010

bma

SUPPLEMENTAL- # 2
February 27, 2014
8:00am

Thank you for your assistance. We hope this provides the information needed to accept the application into the next review cycle. If more is needed please FAX or telephone me so that we can respond in time to be deemed complete.

Respectfully,

John Wellborn

John Wellborn
Consultant

SUPPLEMENTAL- # 2
February 27, 2014
8:00am

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF DAVIDSON

NAME OF FACILITY: Summit Medical Center (8 beds)

I, JOHN WELLBORN, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

John L. Wellborn
Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 26 day of February, 2014, witness my hand at office in the County of Davidson, State of Tennessee.

NOTARY PUBLIC

My commission expires 1-11, 2017.

HF-0043

Revised 7/02

TIFFANY B. POULOSE
NOTARY PUBLIC
STATE OF TENNESSEE
DAVIDSON COUNTY
MY COMMISSION EXPIRES 1-11-2017

SUPPLEMENTAL
#2

SUPPLEMENTAL

FEB 28 '14 PM 1:37

DSG Development Support Group

February 28, 2014

Phillip M. Earhart, HSD Examiner
Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

RE: CON Application CN1402-004
TriStar Summit Medical Center

Dear Mr. Earhart:

At your request, this letter expands on my February 26 response to your second supplemental request, question 3b.

> **3b. The applicant states the de-licensing of eight (8) beds from another HCA hospital is not a viable option since the average occupancy of all HCA facilities in Davidson County is 74.5% and does not take into account peak times of the year. However, please explain the reason eight beds could not be de-licensed from Skyline Medical Center's Madison campus located in Davidson County. According to the 2012 Joint Annual Report, Skyline Madison is licensed for 172 beds, but only staffs 110 beds. The licensed occupancy in 2012 of Skyline Madison campus was 40.2%.**
>
> As additional information, Summit is providing a breakdown of the assignment of Skyline's licensed beds in the format of Part A of the CON application. That information is attached after this page.

Thank you for your assistance. We hope this provides the information needed to accept the application into the next review cycle. If more is needed please FAX or telephone me so that we can respond in time to be deemed complete.

Respectfully,

John Wellborn

John Wellborn
Consultant

4219 Hillsboro Road, Suite 203
Nashville, TN 37215
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SKYLINE MADISON CAMPUS--ASSIGNMENT OF LICENSED BEDS 2/27/14

9. Bed Complement Data

(Please indicate current and proposed distribution and certification of facility beds.)

	Current Licensed Beds	CON approved beds (not in service)	Staffed Beds	Beds Proposed (Change)	TOTAL Beds at Completion
A. Medical					
B. Surgical	37		16*		37
C. Long Term Care Hosp.					
D. Obstetrical					
E. ICU/CCU	14		0		14
F. Neonatal					
G. Pediatric					
H. Adult Psychiatric	66		66		66
I. Geriatric Psychiatric	20		20		20
J. Child/Adolesc. Psych.	21		21		21
K. Rehabilitation					
L. Nursing Facility (non-Medicaid certified)					
M. Nursing Facility Lev. 1 (Medicaid only)					
N. Nursing Facility Lev. 2 (Medicare only)					
O Nursing Facility Lev. 2 (dually certified for Medicare & Medicaid)					
P. ICF/MR					
Q. Adult Chemical Dependency	14		14		14
R. Child/Adolescent Chemical Dependency					
S. Swing Beds					
T. Mental Health Residential Treatment					
U. Residential Hospice					
TOTAL	**172**		**137**		**172**

*These 16 bed are leased to Alive Hospice and are staffed by Alive Hospice.

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF DAVIDSON

NAME OF FACILITY: Summit Medical Center - 8 Beds

I, JOHN WELLBORN, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

John T. Wellborn
Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 28 day of Feb, 2014, witness my hand at office in the County of Davidson, State of Tennessee.

NOTARY PUBLIC

My commission expires November 5, 2014.

JAN M. DANFORTH
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY
My Commission Expires November 5, 2014

HF-0043

Revised 7/02

FEB 7 '14 PM 2:20

LETTER OF INTENT -- HEALTH SERVICES & DEVELOPMENT AGENCY

The Publication of Intent is to be published in the Tennessean, which is a newspaper of general circulation in Davidson County, Tennessee, on or before February 10, 2014, for one day.

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. Sections 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that TriStar Summit Medical Center (a hospital), owned and managed by HCA Health Services of Tennessee, Inc. (a corporation), intends to file an application for a Certificate of Need to convert existing space to eight (8) inpatient medical-surgical beds on the 7th floor of its facility at 5655 Frist Boulevard, Hermitage, TN 37076. The estimated capital cost is $1,850,000.

TriStar Summit Medical Center is a general hospital licensed by the Board for Licensing Health Care Facilities, Tennessee Department of Health, for 188 hospital beds. The project will increase its licensed hospital bed complement to 196 hospital beds. It will not initiate or discontinue any health service, or add any major medical equipment.

The anticipated date of filing the application is on or before February 14, 2014. The contact person for the project is John Wellborn, who may be reached at Development Support Group, 4219 Hillsboro Road, Suite 210, Nashville, TN 37215; (615) 665-2022.

John L Wellborn 2-7-14 jwdsg@comcast.net

(Signature) (Date) (E-mail Address)

CERTIFICATE OF NEED
REVIEWED BY THE DEPARTMENT OF HEALTH
DIVISION OF POLICY, PLANNING AND ASSESSMENT
615-741-1954

DATE: April 30, 2014

APPLICANT: TriStar Summit Medical Center
5655 Frist Boulevard
Hermitage, Tennessee 37076

CN1402-004

CONTACT PERSON: John Wellborn
Development Support Group
4219 Hillsboro Road, Suite 210
Nashville, Tennessee 37215

COST: $1,812,402

In accordance with Section 68-11-1608(a) of the Tennessee Health Services and Planning Act of 2002, the Tennessee Department of Health, Division of Policy, Planning, and Assessment, reviewed this certificate of need application for financial impact, TennCare participation, compliance with *Tennessee's State Health Plan*, and verified certain data. Additional clarification or comment relative to the application is provided, as applicable, under the heading "Note to Agency Members."

SUMMARY:
The applicant, TriStar Summit Medical Center, located in Hermitage (Davidson County), Tennessee, seeks Certificate of Need approval to convert existing space for 8 inpatient medical-surgical beds on the 7th floor of its facility. TriStar Summit Medical Center (TSMC) is a general hospital licensed by the Tennessee Department of Health, Board for Licensing Healthcare Facilities for 188 beds. If this CON is approved for 8 additional medical surgical beds, the licensed bed compliment would increase to 196 beds.

The project involves renovations to 7,406 square feet of total space; 4,406 square feet for 8 med-surg beds on the 7th floor, and 3,000 square feet of space in the medical office building where the Sleep Lab beds are being relocated from the 7th floor. The total cost for the both renovations is estimated to be $1,163,133; $156.78 per square foot. The cost per square foot for the 8 med-surg beds is $235.55, while the Sleep Lab beds are $58.72 per square foot.

TriStar Summit Medical Center is wholly owned by HCA Health Services of Tennessee, Inc., whose ultimate parent company is HCA, Inc. Attachment A.4 contains an organizational chart and information of the Tennessee facilities owned by this facility's parent company.

The total estimated project cost is $1,812,402 and will be funded through a cash transfer from the applicant's parent company to the applicant's division office (TriStar Health System).

GENERAL CRITERIA FOR CERTIFICATE OF NEED

The applicant responded to all of the general criteria for Certificate of Need as set forth in the document *Tennessee's State Health Plan.*

NEED:
The applicant's service area is Davidson and Wilson Counties. The following chart illustrates the population projections for the applicant's proposed service area.

None of the above hospitals reached occupancy of 80% for licensed beds as stated in the Acute Care Bed Need Services criteria.

The applicant provides the utilization of licensed beds by bed type from 2010-2013 and the projected 2015-16 utilization by bed type on page 32 of the application. The applicant notes an increase in occupancy for medical/surgical beds when including fully admitted patients of 9-10% over the Joint Annual Report occupancy data, which does not include observation patient days. The applicant states Summit's actual occupancy for medical beds for CY2013 medical/surgical beds was 87.5%. The projected utilization in 2016 based on 126 medical/surgical beds is 82.5%.

TENNCARE/MEDICARE ACCESS:
The applicant participates in both the Medicare and TennCare Medicaid programs. TSMC has MCO contracts with AmeriGroup, United Community Healthcare Plan, and Select.

The applicant projects gross Medicare revenues of $2,789,528 or 45.7% of gross revenues and TennCare/Medicaid gross revenues of $665,336 or 10.9% of gross revenues.

ECONOMIC FACTORS/FINANCIAL FEASIBILITY:
The Department of Health, Division of Policy, Planning, and Assessment has reviewed the Project Costs Chart, the Historical Data Chart, and the Projected Data Chart to determine if they are mathematically accurate and the projections are based on the applicant's anticipated level of utilization. The location of these charts may be found in the following specific locations in the Certificate of Need Application or the Supplemental material:

Project Costs Chart: The Project Costs Chart is located on page 36 of the application. The total project cost is estimated to be $1,812,402.

Historical Data Chart: The Historical Data Chart is located on page 40 of the application. The applicant reports net operating income of $12,414,108, $18,407,253, and $19,670,547 in years 2011, 2012, and 2013, respectively.

Projected Data Chart: The Projected Data Chart is located on page 42 of the application. The applicant projects 140 patients and 476 patient days in year one and 190 patients and 646 patient days in year two with net operating revenues of $115,186 and $248,694 each year, respectively.

The applicant provided the average charges, deductions, net charge, and net operating income below.

	CY2015	CY2016
Patient Days	140	190
Admissions or Discharges	476	646
Average Gross Charge Per Day	$12,824	$13,249
Average Gross Charge Per Admission	$43,600	$45,047
Average Deduction from Operating Revenue Per Day	$10,347	$10,709
Average Deduction from Operating Revenue Per Admission	$35,179	$36,411
Average Net Charge (Net Operating Revenue) Per Day	$2,477	$2,540
Average Net Charge (Net Operating Revenue) Per Admission	$8,421	$8,637
Average Net Operating Income After Expenses, Per Day	$242	$385
Average Net Operating Income After Expenses, Per Admission	$823	$1,309

Projected Data Chart

The applicant considered no alternatives to the proposed project.

CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTHCARE:
The applicant provides a listing of facilities they most frequently utilize in discharge planning on page 49 of the application.

The applicant believes this project will improve local patients' access to medical/surgical bed in the near term. As a result of Summit Hospital location in Hermitage and it being the only hospital between Davidson County and Wilson County, a large medical community has grown up around Summit. When medical/surgical beds are full, delays in admissions to local patients occur, or forces them to change their providers, perhaps even physicians. The applicant finds it difficult to believe the addition of 8 beds could have any impact on any other hospital.

Currently, the medical/surgical department at Summit has 113.6 FTE registered nurses and 48.9 FTE certified nurse technicians. In year one, the applicant will add 5.50 FTE registered nurses and 1.50 FTE certified nurse technicians. In year two, the applicant will add 6.0 FTE registered nurses and 2.0 FTE certified nurse technicians.

The applicant provides a listing of the schools with which Summit has affiliation agreements with on page 67 of the application.

The applicant is licensed by the Tennessee Department of Health, Board for Licensing Healthcare Facilities and fully accredited by the Joint Commission. The applicant is also seeking accreditation as a Certified Primary Stroke Center.

SPECIFIC CRITERIA FOR CERTIFICATE OF NEED

The applicant responded to all relevant specific criteria for Certificate of Need as set forth in the document *Tennessee's State Health Plan.*

ACUTE CARE BED NEED SERVICES

1. The following methodology should be used and the need for hospital beds should be projected four years into the future from the current year:

   Using the latest utilization and patient origin data from the Joint Annual Report of Hospitals and the most current population projection series from the Department of Health, perform the following:

   Step 1

   Determine the current Average Daily Census (ADC) in each county.

   $$ADC = \frac{\text{Patient Days}}{\text{365 (366 in leap year)}}$$

   Step 2

   To determine the service area population (SAP) in both the current and projected year:

   a. Begin with a list of all the hospital discharges in the state, separated by county, and showing the discharges both by the county where the patient actually lives

(resident discharges), and the county in which the patient received medical treatment.

b. For the county in which the hospital is (or would be) located (service county), determine which other counties have patients who are treated in your county (resident counties). Treat all of the discharges from another state as if that whole state were a single resident county. The total discharges of residents from another state should be calculated from state population estimates and the latest National Center for Health Statistics southeastern discharge rates.

c. For each resident county, determine what percent of their total resident discharges are discharged from a hospital in your service county (if less than one percent, disregard).

d. For each resident county, apply the percentage determined above to the county's population (both projected and current). Add together the resulting numbers for all the resident counties and add that sum to the projected and current population of your service county. This will give you the service area population (SAP).

Step 3

Determine projected Average Daily Census as:

$$\text{Projected ADC} = \text{Current ADC} \times \frac{\text{Projected SAP}}{\text{Current SAP}}$$

Step 4

Calculate Projected Bed Need for each county as:

$$\text{Projected Need} = \text{Projected ADC} + 2.33 \times \sqrt{\text{Projected ADC}}$$

However, if projected occupancy:

$$\text{Projected Occupancy:} \quad \frac{\text{Projected ADC}}{\text{Projected Need}} \times 100$$

is greater than 80 percent, then calculate projected need:

$$\text{Projected Need} = \frac{\text{Projected ADC}}{.8}$$

The Tennessee Department of Health, Division of Policy, Planning, and Assessment calculated the acute care bed need for Davidson and Wilson counties. There are 3,754 licensed beds in Davidson County with a calculated bed need of 2,814 beds in 2018, resulting in a surplus of 940 beds. Wilson County has 245 licensed beds with a calculated bed need in 2018 of 132, resulting in a surplus of 113 beds. The combined total results in a service area surplus of 1,053 beds.

2. New hospital beds can be approved in excess of the "need standard for a county" if the following criteria are met:

a) All existing hospitals in the projected service area have an occupancy level greater than or equal to 80 percent for the most recent Joint Annual Report. Occupancy should be based on the number of licensed beds that are staffed for two consecutive years.

b) All outstanding CON projects for new acute care beds in the proposed service area are licensed.

c) The Health Facilities Commission may give special consideration to acute care bed proposals for specialty health service units in tertiary care regional referral hospitals.

None of the exceptions above apply to this project. a) None of the service area hospital has occupancy of 80%; b) Vanderbilt Medical Center has major bed additions approved but not implemented; c) TSMC is not a tertiary care regional referral hospital.

CONSTRUCTION, RENOVATION, EXPANSION, AND REPLACEMENT OF HEALTH CARE INSTITUTIONS

1. Any project that includes the addition of beds, services, or medical equipment will be reviewed under the standards for those specific activities.

   The applicant responded to Acute Care Bed Need Services.

2. For relocation or replacement of an existing licensed health care institution:

   a. The applicant should provide plans which include costs for both renovation and relocation, demonstrating the strengths and weaknesses of each alternative.

   b. The applicant should demonstrate that there is an acceptable existing or projected future demand for the proposed project.

      The above criterion is not applicable.

3. For renovation or expansions of an existing licensed health care institution:

   a. The applicant should demonstrate that there is an acceptable existing demand for the proposed project.

      The applicant asserts the proposed medical/surgical bed complement expansion will result in an above 80% occupancy during the first two years of operation in the Need Section of the application.

   b. The applicant should demonstrate that the existing physical plant's condition warrants major renovation or expansion.

      The physical plant's condition has nothing to do with the expansion.